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Social Franchising as a Strategy for Expanding Access to Reproductive Health Services

A historical analysis of Population Services International's Green Star service delivery network in Pakistan

Deloitte
Touche
Tohmatsu

IN PARTNERSHIP WITH
Abt Associates Inc.
Population Services International
Meridian Group International, Inc.

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COMMERCIAL MARKET STRATEGIES
1001 G Street, N.W. Suite 400W
Washington, D.C. 20001-4545
Telephone: (202) 220-2150
Fax: (202) 220-2189
Web: www.cmsproject.com

Julie McBride, MPH
Population Services International

Rehana Ahmed, MD
Social Marketing Pakistan

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Julie McBride, M.P.H, Population Services International
Rehana Ahmed, M.D., Social Marketing Pakistan
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About CMS

Funded through a five-year contract with USAID, the Commercial Market Strategies Project (CMS) works in developing countries to expand the private sector s contributions to national family planning and reproductive health goals.

About PSI

Population Services International (PSI) develops and implements programs worldwide to empower low-income individuals and communities to lead healthier lives. A nonprofit group with headquarters in Washington and London, and projects in more than 50 countries on five continents, PSI is the leading social marketing organization in the world.

About the Authors

Julie McBride has been with PSI since 1995. She spent two-and-one-half years in Pakistan contributing to the development of the Green Star project, specifically by adding hormonal contraceptives to the product line. Since 1998, she has been based out of PSI s Washington, D.C., headquarters, where she specializes in developing and marketing pharmaceutical products and health services for PSI programs worldwide. Ms. McBride s professional background includes pharmaceutical marketing, sales, and advertising in the commercial sector. She received her Master s degree in Public Health from New York University in 1995.

Rehana Ahmed, M.D., served as National Medical Coordinator of Social Marketing Pakistan (SMP) from 1995 to 2000, and as Director of Health and Training and a member of the SMP Board of Directors from 2000 to the present. Dr. Ahmed has also held leadership positions with the Family Planning Association of Pakistan, been a lecturer at the Aga Khan University in Pakistan, and practiced as an ObGyn in both England and Pakistan. She received her Bachelor s of Medicine and Surgery from Karachi University in 1967.

PREFACE

In 1996, Population Services International (PSI) and Social Marketing Pakistan (SMP), in conjunction with the Government of Pakistan, began implementing an innovative program to offer family planning services and a range of contraceptive products including oral contraceptives, injectables, and IUDs to low-income urban women. Pakistani women have, on average, more than five children, and this high fertility rate, combined with a young population, has made Pakistan the world s sixth most populous nation and the third most significant contributor to worldwide population growth. At the same time, the majority of married Pakistani women of child-bearing age say that they do not wish to become pregnant, yet only 24 percent are using a family planning method of any kind and nearly one third of these women rely on traditional methods of family planning.

To address this clear, unmet need, PSI and SMP created Green Star, a network of family-planning franchises privately owned and managed clinics and pharmacies in low-income urban areas that offer reliable family-planning services and quality contraceptive products under the Green Star logo. In its first five years, Green Star has grown to include nearly 12,000 doctors, paramedics, and pharmacists in more than 40 cities, and has provided more than 900,000 couple-years of protection to Pakistani women and men.

Green Star s success and the success of similar programs in other countries illustrates the power of *social franchising* to do for social services what it has done for fast food: take a successful small-business model and copy it quickly, faithfully, and on a strikingly wide scale.

Social franchising is just one of many ways in which public—private partnerships and the innovative use of private-sector insights and techniques are helping to make social services more accessible to individuals, families, and communities around the world.

In this case study of one successful program, two of the people who helped build the Green Star Network discuss their experience in detail, from the social and economic conditions that helped make franchised family planning possible in Pakistan the demand for family planning services mentioned above among a population willing to pay for health care, an untapped capacity among private health-care professionals to provide family-planning services to the specific assets and tools necessary to successful franchising the business model, training, quality assurance, and so on to lessons learned from Green Star s mistakes. We hope that aspects of our experience with Green Star may prove helpful to others working in this important and rewarding field.

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Credit is due to all those who have contributed to the development and ongoing operations of the Green Star project, including Zafar Iqbal, Social Marketing Pakistan s Chairman of the Board, and Riaz Mahmood, SMP s Chief Executive Officer, and all the hard-working SMP staff. Several PSI staff have contributed to Green Star s design, development, and operations over the years, including Dana Hovig, Carol Squire, Will Warshauer, Jackie Gaskell, John Hetherington, Sohail Agha, Dominique Meekers, Dick Johnson, Steve Chapman, and Judith Timyan.

Finally, PSI and SMP are extremely grateful to the agencies that have contributed funds to support the Green Star project, most notably Germany s Kreditanstalt fur Wiederaufbau (KfW) and the Packard Foundation, without which the project would not have been possible.

ACRONYMS

AID/W	U.S. Agency for International Development/Washington
AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
CA	cooperating agency
CBD	community-based distribution
CBT	competency-based training
CMS	Commercial Market Strategies project
COTR	contracting officer s technical representative
CPR	contraceptive prevalence rate
CS	child survival
CSM	contraceptive social marketing
CRS	contraceptive retail sales (Nepal)
CSR	corporate social responsibility
CYP	couple-year of protection
DCA	Development Credit Authority
DFID	Department for International Development (UK)
DHS	demographic and health surveys
EC	emergency contraception
FP	family planning
FPSD	Family Planning Services Division
GDP	gross domestic product
GoP	Government of Pakistan
GSN	Green Star Network
HIV	human immunodeficiency virus
IEC	information, education, and communication
IFC	International Finance Corporation
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHPIEGO	JHPIEGO Corp.
KAP	knowledge, attitudes, and practice
KfW	Kreditanstalt fur Wiederaufbau
KSM	Key Social Marketing Program (The Futures Group, International)
LHVs	lady health visitors
MCH	maternal and child health
M&E	monitoring and evaluation
MoH	Ministry of Health
mohalla	English translation: neighborhood
MoPW	Ministry of Population Welfare
MOU	Memorandum of Understanding
MSI	Marie Stopes International
MWRA	married women of reproductive age
NGO	nongovernmental organization
OC	oral contraceptive
ORS/ORT	oral rehydration salts/therapy
PAC	post-abortion care
PCPS	Pakistan Contraceptive Prevalence Survey
PDHS	Pakistan Demographic and Health Survey
PFFPS	Pakistan Fertility and Family Planning Survey

PK	Pakistan
PHN	population, health, and nutrition
PNC	postnatal care
POP	point of purchase
PRB	Population Reference Bureau
PROFIT	Promoting Financial Investments and Transfers Project
PSI	Population Services International
PVO	private voluntary organization
RH	reproductive health
RHC	reproductive health care
RP	results package
RTI	reproductive tract infections
SMP	Social Marketing Pakistan
SO	strategic objective
SOMARC	Social Marketing for Change Project
STD/STI	sexually transmitted diseases/infections
TAG	technical advisory group
TFGI	The Futures Group International
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
VSC	voluntary surgical contraception

1. THE GREEN STAR NETWORK

Fig. 1. The Green Star Network in Pakistan

INTRODUCTION

Rapid population growth and the poor health status of women in Pakistan are to a large extent consequences of an inadequate health care system, particularly the inability of the system to meet women s reproductive health needs. While Pakistan can be credited with having one of the world s oldest national family planning programs, inconsistent strategies and weak implementation have resulted in ongoing program failures. Resource constraints have also placed serious limitations on the public sector s ability to provide access to quality reproductive health services. The private sector, while playing a significant role in health care delivery in Pakistan, has had only limited involvement in the provision of family planning services. As a result, geographic coverage of family planning services is inadequate, with services accessible to only 25 percent of the population (Rosen, 1996).

In recognition of the need to expand access to family planning, the Government of Pakistan developed a national plan to extend services to rural areas by providing training to female health workers posted in rural health centers (Pakistan Economic Survey, 1998—99). At the same time, to enable the government to channel resources toward meeting rural needs, Pakistan sought ways to involve the private sector in expanding access in less developed urban areas. Population Services International (PSI) and its local affiliate, Social Marketing Pakistan (SMP), designed the Green Star Network of family planning service providers to contribute to the Government of Pakistan s family planning goals by complementing its rural-based public service expansion strategy with an urban-based private sector strategy.

The Green Star Network was designed to harness the potential of private sector health providers who were willing to upgrade their knowledge and skills in order to add family planning to the constellation of services they offered. In 1995, PSI/SMP began implementing the Green Star Network with funding from the government of Germany s Kreditanstalt f r Wiederaufbau (KfW). The aim of the Green Star Network is to contribute to increased use of contraception by making **high** quality family planning services and products more widely available to low-income people throughout urban Pakistan, at prices they can afford. (Low-income people are those earning between rupees [Rs] 4,000 and 6,000 per month.)

Since its inception in 1995, the Green Star Network has grown to include more than 11,000 private health providers in more than 40 cities, receiving more than 10 million client visits per year. Over the same period of time, contraceptive prevalence rates among currently married women of reproductive age in Pakistan have increased from 17.8 percent in 1995 to 23.9 percent in 1997. Further, while the use of oral contraceptive pills (OCs) and injectable contraceptives (injectables) in Pakistan remained virtually unchanged between 1991 and 1995 prior to the Green Star Network intervention both methods experienced a dramatic rise in use between 1995 and 1997; during that time, use of OCs increased 29 percent, and use of injectables, 40 percent. IUD use also increased substantially over the same period, by 62 percent (PDHS, 1990/1991; PCPS, 1994—95; PFFPS, 1996—97).

The success of the Green Star Network has demonstrated that good family planning services can be delivered effectively and efficiently to low-income populations through the private sector if health providers are equipped and motivated to do so. By designing the Green Star Network to operate as a social franchise, PSI and SMP provided both the means (through training, ongoing technical support, and supplies of contraceptives and information, education, and communication materials) and the incentive (increased clientele through affiliation with the Green Star brand) to health providers to deliver quality services. The results have been extremely positive. This report describes the principles behind the design of the network and its various operational components, achievements, and challenges. This report also documents the development and growth of the Green Star Network and shares hard-gained experience that may be valuable to others who are implementing similar interventions.

BACKGROUND: THE PAKISTAN CONTEXT

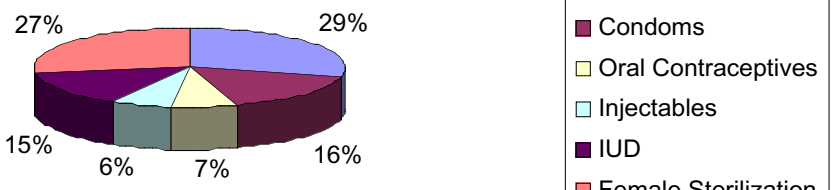
Pakistan, with a population of 150 million (PRB, 2000), is the world s sixth most populous nation and the third most significant contributor to worldwide population growth. High fertility rates (5.6) combined with a young population (43% below the age of 15) put Pakistan s population growth rate at approximately 2.8 percent per year in 2000 (PRB, 2000), higher than that of any other large Asian nation. At this rate, Pakistan s population will double in just 25 years (PRB, 2000), resulting in a dramatically increased burden on already scarce resources. Per capita income (based on GDP) in Pakistan is currently just US$ 470 per year. An estimated 34 percent of the population lives in poverty, earning less than US$ 1 per day (WDI, 1997). During the 1990s, unemployment doubled in Pakistan, and poverty grew by 41 percent. In just four years, the proportion of people consuming fewer than the recommended 2,200 calories a day increased 32 percent (NIPS, 1997). Population pressures are degrading natural resources such as arable land and water at an alarming rate (Rosen, 1996). Already, 60 percent of Pakistan s population has no running water or other basic amenities.

Family planning in Pakistan

Although population growth in Pakistan is high, national trends in family planning are positive, with fertility rates declining and contraceptive use increasing. At the same time, there is much progress to be made. Successive fertility surveys have documented a large and consistent unmet demand for family planning in the country. The latest such study (PFFPS, 1996—97) reveals that while 61 percent of married women of reproductive age (MWRA, women between 15 and 49 years old) say that they are currently sexually active, but that they do not wish to become pregnant at this time, only 24 percent are using a family planning method of any kind. The remaining 37 percent are at risk of having an unintended pregnancy.

Among women using contraception, a large proportion (30%) rely on traditional methods of family planning, which are not as effective as modern methods. The remaining women use surgical contraception (25%), condoms (17.7%), IUDs (14.4%), oral contraceptives (6.9%) and injectables (5.9%) (fig. 2). Use of female-controlled spacing methods IUDs, oral contraceptives, and injectables is particularly low and represents a much smaller proportion of the method mix than in most other Asian countries. Moreover, contraceptive discontinuation is over 80 percent for women who have ever used pills or injectables and over 60 percent for those who have ever used an IUD. Women site side effects as a primary reason for discontinuing their method (PFFPS, 1996—97; SMAR, 1996).

Figure 2: Contraceptive Methods Used in Pakistan



Source: PFFPS 1996—97. Numbers do not add to 100 percent because of rounding

Pakistan s low contraceptive prevalence rate (CPR) has been attributed to several factors, including an insufficient public sector supply of family planning services, inconsistent availability of contraceptives, and a lack of accurate, reliable information about family planning methods, for health providers as well as consumers.

Other health and social indicators in Pakistan

Other health and social indicators reflect the poor circumstances of women in Pakistan. In 1997, 45 percent of women of reproductive age were found to be anemic (PFFPS, 1996—97), a factor associated with maternal deaths as well as malnutrition. More than three-quarters (76%) of all women in Pakistan are illiterate (WDI, 1997). The country is one of the few in the world with a higher number of men than women (92 women for every 100 men) (WDI, 1997), owing in large part to the low social status of women and the impact of their consequent treatment on health. Maternal and child mortality rates are correspondingly very high: one child dies for every 10 live births (91 per 1,000) (PRB, 2000), while the country has one of the highest maternal mortality rates in the world estimated at 340 per 100,000 nationwide (MoH/MoPW/GoP, Reproductive Health Package). Most of these deaths are preventable. Moreover, these figures do not convey the serious health problems among mothers and infants who survive.

The health sector in Pakistan

The Government of Pakistan (GoP) now spends less than one percent of its budget on health care (MoH/MoPW/GoP, Reproductive Health Package) and even less on family planning services. Family planning is administered by the Ministry of Population Welfare (MoPW) through a system parallel to (as opposed to integrated with) the Ministry of Health s (MoH) primary care system. Per capita spending on family planning in Pakistan (approximately US$ 0.30) is significantly lower than that of neighboring countries such as Bangladesh (approximately US$ 1.40) (Rosen, 1996).

In all, there are about four times as many public sector primary care facilities (approximately 6,000, according to Rosen, 1996) as there are family planning clinics run by the population welfare department (approximately 1,500, according to the PK Economic Survey, 1998—99). As a consequence, an estimated 85 percent of the population has access to primary health care (WDR, 1997), while only 25 percent has access to family planning services (Rosen, 1996). Public sector family planning clinics reach only 10 percent of the population and half that or less in rural areas

(Rosen, 1996). Nongovernmental organizations (NGOs) and private clinics reach the other 10 to 15 percent of the population that has access to family planning services (Rosen, 1996).

The MoPW administers family planning services through a thinly spread network of facilities that provide all contraceptive methods except sterilization. These facilities include approximately 1,500 family welfare centers and 130 mobile service units. Sterilization is available through another 80 specialized sterilization clinics run by the MoPW. In addition, approximately 5,000 traditional midwives are employed to provide educational messages about family planning to their communities (Rosen, 1996).

Problems with staff motivation, training, and supervision, and with contraceptive supply have limited the effectiveness of public sector family planning clinics. For example, a 1992 field survey found that only 75 percent of family welfare centers had a full range of family planning methods available (Rosen, 1996). Weak supervision has resulted in high absenteeism of family welfare staff. Other research shows that the care offered at public sector facilities is highly variable and often of dubious quality (Population Council, 1998). As a result, consumers lack confidence in the public health system and either turn elsewhere for services or, as is often the case with family planning, go without services. A 1992 survey found that family welfare centers saw an average of only three family planning clients a day (Rosen, 1996).

The private sector plays a significant role in health care delivery in Pakistan. According to the Pakistan Economic Survey of 1998—99, the private sector accounts for nearly two-thirds of all health expenditures in the country. The Pakistan Medical Association reports that roughly one-half of all registered medical doctors in Pakistan 40,000 of about 80,000 (MoH, 1998—99) practice in the private sector. While the private sector in Pakistan is well developed, however, its facilities are largely urban, and they offer primarily curative treatment, as opposed to preventive services like family planning. Further, the private sector is highly unregulated, resulting in varying qualities of care (PK Economic Survey 1998—99).

Reluctance among private sector providers to deliver family planning services is based on the lack of training in and practical exposure to this particular specialization. Because family planning is considered to be a low-prestige field, with no recognition for specialization, there is little professional incentive to specialize in family planning. In addition, many providers share consumers negative attitudes and misconceptions about contraceptive methods and would rather not get involved in this controversial area of service delivery (Rosen, 1996; Semiotics, 1996). In short, there is tremendous untapped potential among private sector providers to deliver family planning services.

From social marketing of condoms to franchising family planning services: Evolution of the PSI program in Pakistan

To increase contraceptive use in Pakistan, the Government of Pakistan and USAID introduced a jointly operated condom social marketing project in 1986. PSI, Woodward Company (a local commercial health products marketing company), and the National Development Finance Corporation (NDFC) were contracted to implement the project. The project launched Sathi condoms in January 1987. In 1991, USAID and the GoP reorganized the project implementation structure to expand the functional role of PSI (figure 4), and PSI established a local NGO, Social Marketing Pakistan (SMP), to operate the project.

In 1993, in accordance with the Pressler Amendment, USAID discontinued all assistance to Pakistan, although the social marketing project was to continue operating until its funds were depleted. To compensate for the impending loss of USAID support, the project attempted to push itself toward financial self-sufficiency by increasing the price of Sathi. The result was devastating: Sathi sales plunged from six million per month to one million per month.

PSI s program goals and approach to pricing stipulate that a social marketing program s or provider network s sustainability is predicated on delivering quality products and services at prices that are affordable to a large number of satisfied customers. A review indicated that the Pakistan project would not be able sustain its impact without external funds to subsidize the cost of condoms. In 1994, the Ministry of Public Works contracted with PSI/SMP to maintain social marketing of Sathi. Sales revenues covered most of the operating costs. PSI donated the additional funds required to maintain operations and to support its resident technical advisor while it looked for a donor to help fund the project.

In October 1994, the German government s development bank, Kreditanstalt fur Wiederaufbau (KfW), contracted with SMP to continue marketing Sathi condoms, expand the social marketing activities to include IUDs and a second brand of condoms, and establish a service delivery network through which women could obtain IUD insertions. In 1995, KfW provided additional funds for the introduction of OCs and injectables. Project expansion was based on the premise that greater contraceptive choice leads to higher contraceptive acceptance. Providing a service delivery component was viewed as necessary to the success of marketing clinical methods like IUDs and injectables, as their acceptance is highly dependent upon quality care, the availability of which was extremely limited in Pakistan.

Under the new funding arrangement, PSI continues to provide technical assistance through a subcontract with SMP. Organization and management of the project differs from the initial arrangement in two major ways. First, there is only one prime contractor SMP. Second, MoPW and KfW do not participate in day-to-day decision making; instead, they provide policy guidance through review and discussion of annual plans, while delegating day-to-day management to SMP (figure 5).

PSI/SMP launched the Green Star Network and IUD on a pilot basis in 1995 and expanded the program in 1996. OCs, injectables, and a second brand of condom were launched in 1996 (Davies and Agha, 1997). Section 2, entitled Design, below, describes the process of creating the network and the structural changes undertaken by SMP to accommodate this rapidly growing project.

Figure 3. Milestones in Green Star s development

Year	Milestone
1986	PSI introduces condom social marketing to Pakistan with USAID funding.
1991	PSI establishes Social Marketing Pakistan (SMP), a local NGO, to implement project.
1993	USAID withdrawals funding from Pakistan.
	Condom social marketing is continued with PSI s own funds.
1995	Government of Germany, via KfW, provides PSI/SMP with funds for continued condom social marketing, Green Star Network, and IUD.
	PSI/SMP begins implementing Green Star Network pilot.
	300 female GPs are successfully recruited and trained as Green Star providers in the cities of Karachi and Rawalpindi/Islamabad.
1996	PSI/SMP introduces the MultiLoad IUD under the Green Star umbrella.
	Training for female MDs and paramedics is expanded to other districts of Karachi and to the city of Lahore.
	KfW provides PSI/SMP with funds for hormonal contraceptive social marketing.
	PSI/SMP introduces oral contraceptive Nova and injectable contraceptive NovaJect under the Green Star umbrella.
1997	Green Star pilot evaluation is conducted.
	Revisions are made to project design based on evaluation findings.
	Green Star Network is expanded to include 1,1240 female MDs/paramedics; 2,724 male MDs; 295 pharmacists; and 1,038 junior paramedics.
	PSI/SMP introduce Touch condoms under the Green Star umbrella.
1998	Network is expanded to include 1,803 female MDs; 3,608 male MDs; 2,529 pharmacists; and 2,142 junior paramedics.
1999	Network is expanded to include 2,352 female MDs; 4,258 male MDs; 2,586 pharmacists; and 2,142 junior paramedics.
2000	Network comprises more than 11,000 Green Star providers: 2,571 female MDs; 4,258 male MDs; 2,586 pharmacists; and 2,142 junior paramedics in over 40 cities throughout Pakistan.
	Additional funding received from Packard, Hewlett, and Dfid.

Figure 4. History of PSI/SMP funding in Pakistan

Donor	Amount	Period of funding	Funding specifications
USAID	US$ 3.6 million of approx US$ 30 million was allocated to PSI*	1986—Sept 93	Condom social marketing
PSI funds	Approx. US$ 750,000	Sept 93—ongoing	Bridge funding, technical assistance, fundraising support
KfW	US$ 15 million (DM 30 million) US$ 9 million (DM 18 million)	Jan 95—Dec 00 Jun 96—Dec 00	GSN, condoms, IUD Hormonals, GSN
Packard	US$ 2.3 million	Jan 00—Dec 01	GSN strengthening
Dfid	US$ 3.8 million	May 00—Nov 01	Condom commodity support; BCC
Hewlett	US$ 600,000	Jan 00—Jan 01	Hormonals
Total	US$ 35,050,000 to PSI	1986—2002 (16 years)	

Note: US$ calculations are based on 1999 yearly average exchange rate of US$ 1 = DM 2

* Supplemental amounts totaling approximately US$ 30 million were awarded over the same period of time to the co-implementing agencies for CSM including the Government of Pakistan s MoPW and the Woodward Company.

2. DESIGN

The objective of the social marketing program from the outset was to increase use of contraceptives in Pakistan. To this end, the program was designed to increase the availability and quality of family planning services, especially making choice of method an option for more low-income Pakistanis. The network began by offering a comprehensive package of family planning services that included provision of counseling, hormonal methods prescription and administration, and IUD insertions. Over time, variations of the family planning service delivery package have been added to accommodate a broader range of service providers and thereby facilitate the expansion of the network. Today, as described in section 6, Next Steps, below, the project is further expanding its service scope to include reproductive health services such as VSC, STI treatment, and post-abortion care (PAC).

Who are the stakeholders, and how have they been involved with Green Star?

The Green Star Network is targeted to low-income women and men with unmet demands for family planning. These consumers participated in research to assess their particular needs, concerns, expectations, and preferences related to family planning services.

Health care providers are also regarded as project beneficiaries and were included in the development of the service delivery protocols and training curricula. Formal contacts with health professionals were made through the Pakistan Medical Association, whose endorsement has proved to be important to the program s credibility.

NGOs

Key family planning-related NGOs were involved in the Green Star project design and continue to be involved in its implementation. These groups, including the Family Planning Association of Pakistan (FPAP) and Marie Stopes International (MSI), are part of the Green Star Network referral system. PSI/SMP also collaborates with the Futures Group Key social marketing project in Pakistan by sharing information and coordinating training programs to maximize coverage and impact of family planning services. In addition, PSI/SMP consulted with JHPIEGO for development and evaluation of training curricula.

Private sector organizations

The involvement of Schering/Medipharm and Organon as product suppliers has been extremely important to the success of the project. Their understanding of the program s needs and their responsiveness to PSI/SMP requests for technical information and support has ensured that product is always available and appropriately marketed in Pakistan. Other private organizations involved in program design and implementation include subcontractors such as advertising agencies, distributors, and research firms.

The Government of Pakistan

PSI/SMP works with the Government of Pakistan to ensure that their program activities complement one another. For example, the government s Population Welfare Program seeks to narrow the gap between met and unmet needs for family planning by expanding access to quality health care. The GoP s program is focused primarily on extending services to the rural population, while PSI/SMP works to maximize coverage in urban areas (PK Economic Survey, 1998—99).

Green Star donors

There are several donors to the Green Star project, including KfW, DFID, and the Packard and Hewlett Foundations. Each donor has its own reporting requirements, and PSI/SMP generates monthly and quarterly reports to keep donors abreast of project activities and progress in meeting objectives.

How will services be delivered? The franchise model

As noted by Smith, 1997, and Laukamm-Josten, 1998, franchising is a highly successful, commercial mechanism to replicate a proven business strategy. Within the commercial sector, it is used to expand the distribution of products and services of a specified quality by harnessing the skills and interest of private sector entrepreneurs (Smith, 1997). Social franchising applies the principles of franchising to initiatives that are designed, not to generate revenue for the franchiser, but rather to bring about social change. There is a revenue-generation aspect to social franchising, which serves to motivate the private sector to participate. But the financial benefits do not extend to the franchiser, as they do in commercial franchising. The theory behind social franchising is akin to that of social marketing; in both cases, proven commercial strategies are applied to the social sector to achieve social goods, such as improving the health status of a population.

According to Laukamm-Josten (1998), an organization is engaged in social franchising if:

- a group has been allowed to distribute services under an organization s name using that organization s project plan or system of operations; and
- in exchange for this privilege, certain criteria have been fulfilled, such as adherence to specified quality standards.

Three key components must be in place for social franchising to function:

- the business format;
- the brand; and
- quality assurance.

The business format defines the services that are being franchised and how they must be delivered by franchisees. The brand links a particular service delivery point with the franchise in the minds of the consumers. The brand is advertised to consumers as an indication of high quality, affordable services; if marketed properly, over time the brand will bring with it a great deal of equity. The primary benefit to franchisees is the increased business they generate by being associated with a high equity brand. In order for a franchise to succeed, the brand must deliver what it claims to deliver. Thus, a mechanism must be in place to assure consumers of the quality they will receive from franchisees. Quality assurance includes training and support provided by the franchiser to enable franchisees to deliver goods and services in accordance with specified quality standards. Monitoring and evaluation mechanisms ensure that franchisees are in fact operating in accordance with the protocols of the franchise.

Social franchising is well suited to expanding and improving reproductive health services in developing countries, especially in countries with overburdened public health systems and underutilized private sectors. Specialized reproductive health services and longer term family planning methods for example, voluntary counseling and testing, management of sexually transmitted infections, and post-abortion care require trained providers and the establishment of minimum quality standards. Social franchising provides a mechanism for expanding access to

high quality reproductive health services. Increasing the number of providers delivering quality reproductive health services expands physical access; including pricing policies in the business format improves economic access; and brand advertising improves cognitive access to family planning.

In addition to benefiting consumers, franchising benefits franchisees and the franchiser as well. Franchisees benefit from training and technical support, which improve their ability to meet growing client demands, and from national and local franchise promotions, which create demand for their services. The franchiser benefits by using an efficient mechanism to replicate a proven service delivery model, thereby substantially increasing social impact.

The progression from social marketing to social franchising

Social marketing is suited to delivering reproductive health products when product information can be given through educational materials and advertising campaigns, and when the client does not need a service provider for guidance or to administer a method. However, use and continuation of longer acting contraceptives such as injectables and IUDs is highly dependent upon skilled providers. As PSI/SMP planned to expand its program from condom social marketing to providing these methods and other more technical reproductive health products, it faced both a program necessity and an ethical obligation to ensure that clients had access to quality services. After a thorough assessment of the reproductive health service delivery system in Pakistan, social franchising was determined to be the most viable way of ensuring access to quality services.

Developing a model for social franchising

There are two principal types of a social franchise, with several variants of each model: stand-alone franchises and fractional franchises (Smith, 1997; Laukamm-Josten, 1998). In a stand-alone social franchise, the franchiser provides the infrastructure and equipment, and then franchises the space to providers. Operating costs are shared by the franchiser and franchisee. PROSALUD in Bolivia is an example of a stand-alone social franchise. In a fractional social franchise, a package of services is added to an existing business to a service delivery point in the case of a reproductive health franchise to create an additional service and income stream for the franchisee.

These two different models are appropriate in different circumstances. A fractional social franchise may be more effective where there is a supply of health providers with established businesses and underutilized capacity who can form a pool of franchisees. A stand-alone model of service delivery may be called for in countries that have a supply of health providers without sufficient infrastructure and equipment to provide quality services.

Each model of social franchising has advantages and disadvantages. The main benefit of stand-alone franchising is that it allows better control of the quality and pricing of franchisees services. Its main disadvantage is that it requires a great deal of seed capital to implement and is expensive to replicate. The main advantage of fractional franchising is that it can be replicated efficiently, by building on existing resources and infrastructure. The franchiser in this model does not need to have large amounts of seed capital, as the franchiser is not providing infrastructure. Because this model builds on the capacity of already functioning businesses, it is likely to be more sustainable in the long term. The main disadvantage of the fractional model is the difficulty and complexity it presents in controlling the quality and price of services.

Green Star

PSI/SMP designed the Green Star model of franchising to meet Pakistan s specific needs and circumstances:

- high unmet demand for family planning;
- consumer willingness to pay for health services as demonstrated by the high use of the private sector for curative treatment, even among the poor;
- limited capacity of the public sector to meet its citizen s reproductive health needs;
- a highly developed private health sector, with an ample supply of health practitioners with established practices;
- underutilized capacity in the private sector to provide reproductive health services; and
- low levels of reproductive health knowledge among private sector service providers, with limited opportunities for professional training and continuing education.

These circumstances all supported the development of a fractional model of social franchising in Pakistan.

The Green Star Network is designed to provide already functional service delivery points with a franchisable package of reproductive health services of specified quality. Partnerships are formed between PSI/SMP (the franchiser) and selected providers (the franchisees), with the agreement that these providers will integrate a defined package of reproductive health services and deliver those services according to quality standards established by PSI/SMP. In return, the provider/franchisee receives specialized support, training, and rights to the franchise brand, as long as the franchisee maintains minimum quality standards, monitored by PSI/SMP. The franchisee also benefits from the brand equity created by the franchiser.

The relationship between franchiser and franchisees is governed by an enforceable contract. This feature is particularly important because the success of the franchise depends on the reputation of the brand. If PSI/SMP finds a franchisee to be in breach of contract that is, if monitoring reveals that quality standards are not consistently met then PSI/SMP reserves the right to remove the provider from the franchise. However, PSI/SMP s ongoing technical support is intended to identify and solve problems for example, through training or by upgrading the franchisees skills before they get to this point.

Operational components of the network

This section describes how each of the components of a social franchise business format, brand, and quality assurance functions in the Green Start Network.

The business format: Service delivery packages and protocols

As noted above, the business format defines the services that are being franchised and how they must be delivered by franchisees. The Green Star Network addresses the major elements of its business format as follows.

Service delivery packages. Green Star Network service delivery packages to date have been restricted to family planning services. The network began with a comprehensive package of family planning services that included provision of counseling, prescription and administration of hormonal methods, and insertions of IUDs. Because of restrictions on who can give pelvic exams in Pakistan, however, only female medical doctors could offer this package of services. Over time, variations of the service delivery package have been added to accommodate a broader range of service providers and thereby facilitate the expansion of the network. The Green Star Network now includes several different service delivery packages, offered by different types of service providers. These are:

Family planning counseling, prescription and administration of hormonal methods and IUDs provided by licensed female medical doctors and selected female paramedics operating privately owned clinics in low-income urban areas. (Because of cultural restrictions placed on who can give pelvic exams in Pakistan, only female providers are selected for this service delivery package.) These providers are referred to as Green Star 1 (GS1) providers.

Family planning counseling and prescription and administration of hormonal methods provided by licensed male medical doctors, and female doctors who do not have the professional settings or interest to provide IUDs, operating privately owned clinics in low-income urban areas GS 2 providers. This package is now also provided by junior paramedics, often those who work as lady health visitors (LHVs), operating privately owned clinics in low-income urban areas GS 4 providers.

Family planning counseling and referral provided by licensed pharmacists operating privately owned pharmacies in low-income urban areas. This cadre of providers is called GS 3.

PSI/SMP has begun to expand the range of reproductive health products offered through selected Green Star providers to include such options as VSC, testing and treatment for sexually transmitted infections and HIV, post-abortion care, and maternal and child health services.

Service delivery protocols. In order to ensure that quality standards would be high and uniform across all Green Star outlets, PSI/SMP developed protocols describing how the franchised service should be delivered. The protocols were modeled after the quality of care framework developed by Bruce and Jain (Bruce 1990; Jain 1989, 1992; Jain and Bruce 1993, 1994; Jain et al. 1992), widely recognized as a gold standard in quality health care. The Bruce–Jain framework revolves around six defining elements, which have been adapted slightly for Green Star:

- choice of methods;
- correctness and completeness of information given to users;
- technical competence of providers;
- client—provider interaction;
- continuity of care; and
- appropriateness and acceptability of services

The Green Star training curriculum was developed to provide the knowledge and skills required to deliver services according to these protocols. While the training workshops made clear what was expected of providers, the protocols were not distributed as such. PSI/SMP is currently developing detailed service delivery protocols for distribution to all Green Star outlets (see section 7, Lessons Learned, for more on this).

The Green Star Brand

In order to create a franchisable brand of reproductive health services, consumer research was conducted to identify a symbol that people in Pakistan would recognized easily and associate with quality and trustworthiness attributes identified as important to consumers. After testing several logos, colors, and tag lines, the Green Star symbol was selected as the most compelling way to identify the franchise, along with the tag line Trustworthy Family Planning. To represent family planning, two people were included in the center of the star, representing either a couple or two children. (The Green Star has the advantaged of being easily recognized in both visual and verbal media, by color and form. The drawbacks of adding human figures to the star will be discussed below, under Lessons Learned.) The Green Star logo was registered as a trademark in Pakistan in order to protect it from being copied and misused by providers who are not a part of the network and who may not meet its standards of care.

Rollout of the brand

Signboards with the Green Star logo are presented to all franchisees and installed outside their outlets to identify them as members of the Green Star Network. Different sizes and styles of signboards were developed to represent the different services available. For example, doctors who are trained to provide the full range of services, including IUDs, are given large, individually customized signboards for their clinics, while doctors who are not trained in IUD insertions receive smaller standardized square signboards. Pharmacists and paramedics also have their own smaller standardized metal signs.

The Green Star logo is also placed on the packaging and inserts of all Green Star contraceptive products to create brand equity and a sense of ownership among Green Star providers.

Advertising and promoting Green Star

PSI/SMP designed an advertising campaign to create awareness of the Green Star brand and what it symbolizes and to create demand for services at outlets displaying the Green Star symbol. The campaign highlights Green Star service features such as quality and affordability, informs consumers how to find a Green Star outlet, and urges them to do so for their families well being and future prosperity.

Once a critical mass of about 150 franchisees was established and operating in Karachi, the advertising campaign was launched. This figure for critical mass was an estimate of the minimum number of providers that would be necessary to meet initial demand created by the campaign. The figure of 150 sites was also determined to be large enough to make the network visible to consumers, without which the advertising campaign would be ineffective. The Green Star ad campaign was initially launched only in Karachi. Later, it was rolled out nationally to coincide with the expansion of the network nationwide. Media used to communicate the Green Star message included television, radio, print, and outdoor (billboard and wall-painting). Promotional materials for the Green Star brand, including pamphlets, stickers, and posters, were also developed and placed at points of purchase. In Karachi, a local group was hired to distribute 200 pamphlets around each of the 150 clinics in the city, promoting individual service providers by stamping them with clinic names and addresses. Several local launch events held to coincide with the national rollout drew large audiences that included representatives from the government, press, and donor organizations. At each launch event, a certificate ceremony formally recognized new members of the Green Star Network. These events received a great deal of positive press coverage and contributed to heightening awareness and perceptions of the network.

Green Star continues to run ads based on consumer research. Campaign messages have addressed key barriers to accessing family planning identified in local research, including mistrust of existing family planning service providers, lack of knowledge about where to seek quality services, lack of confidence in the safety or efficacy of the methods available, and lack of social support for family planning from husbands and the larger family and community (SMAR, 1996). In response, advertising messages have reinforced the need to consider family planning, and a television campaign modeled how to discuss the subject with a spouse. Messages have also highlighted the availability of trustworthy and quality services at service delivery points displaying the Green Star. The campaign s call to action has consistently been to encourage consumers to seek advice about family planning from a Green Star provider.

PSI/SMP also promotes the Green Star through community events and public relations activities. Events that have proved to be successful include the following:

Free medical camps. Free medical camps are organized to provide consumers with counseling, examinations, and treatment. Free samples of pharmaceutical products, including condoms, oral contraceptives, and antibiotics, are also distributed. These camps are held in the vicinity of Green Star clinics. Individual medical camps average 200 attendees per day and have registered as many as 650 visits, with 100 clients counseled for family planning. Of those who come for family planning, over 30 percent become new acceptors, and neighborhood providers have seen notable increases in clients after these events.

Community events. PSI/SMP also regularly sponsors community sports and musical events, such as *kabadi* wrestling matches, which are very popular among Pakistani men. Other local events include theatrical shows, photography exhibits, walks, and bicycle races. During these events, a commentator promotes Green Star products and services.

Visits from community motivators. With the assistance of Green Star field trainers, female community motivators have visited resident women in catchment areas around Green Star clinics to provide family planning information and inform women about their local clinics.

Town-storming. Town-storming activities are undertaken in small towns: the area sales manager and local distributor arrange multiple promotional activities, such as displaying banners and posters, improving product display, and increasing products shelf levels at retail outlets.

Mohalla. Mohalla (neighborhood) meetings, begun in spring 1998, have been an especially successful form of community-based promotion. These meetings, which are advertised by individual Green Star providers, are held in enclosed areas, often a Green Star doctor s clinic. Small groups of women and both Green Star trainer-doctors and Green Star clinic providers are present. These private venues provide opportunities for questions and concerns to be addressed and for one-on-one counseling to be given, an arrangement that increases the comfort level of potential clients, as well as the value of information they receive. Many women in Pakistan have limited access to information, given restrictions placed on them by husbands and the culture. Mohalla meetings bring information to them in their communities at places that are safe and where husbands will allow them to go. Nothing is more powerful at motivating behavior change than the interpersonal communications women and providers have at these meetings. On average, PSI/SMP conducts 28 mohalla meetings per month, with 70 to 75 attendees per meeting, directly reaching 24,000 women per year. As many as 20 percent of attendees at these meetings schedule family planning appointments with Green Star on the spot. Women have largely been the invited guests at mohalla meetings. However, the first mohalla meeting for couples was held in July 1999, drawing a sizable crowd of 150 people. Beyond promoting family planning services, provider-sponsors also discuss oral rehydration salts, nutrition, and other health-related subjects.

Trade promotions. To help motivate Green Star vendors to market their products and services, PSI/SMP hold trade promotions such as bonus competitions and offers. Seminars and workshops are held for Green Star trained service providers, including pharmacists, who also receive newsletters and technical updates such as the bimonthly *PSI/SMP Matters*.

Involving opinion-leaders. Finally, Green Star public relations and advocacy shape the views of influential groups, including policy makers, journalists, and thought leaders.

Green Star s campaign of advertising and promotions has resulted not only in increased consumer demand for services at Green Star outlets, but in increased interest among service providers to become members of the franchise, as well. Today, there is near universal awareness in Pakistan of the Green Star and what it symbolizes. Research carried out in low-income urban areas in 1997 (AAL), found that 93 percent of respondents recognized the Green Star logo and were able to identify it correctly as a symbol of high quality family planning at affordable prices.

Green Star advertising and promotions continue to target unmet demand for contraceptive health services among women and men with messages designed to reinforce perceived benefits of family planning, encourage couples to communicate about family planning, increase acceptability of modern contraceptives, position Green Star as a trusted source of family planning advice, and motivate couples to seek out more information from Green Star outlets.

Assuring quality franchisees

Selecting, training, and supporting providers who have the greatest likelihood of succeeding as franchisees are all important parts of quality assurance. From the outset, PSI/SMP established a transparent process for selection with clearly defined selection criteria. With experience, these criteria were revised to reflect qualities predictive of successful Green Star outlets. Green Star training and follow-up have also been adapted to take advantage of experience and lessons learned.

Selection criteria

Today, different types of service providers physicians (both female and male), paramedics, and pharmacists play diverse but critical roles in Green Star s delivery of family planning services. When the project began, however, the emphasis was on creating a network of providers whose services would include insertion of IUDs. For this reason, franchisee selection was limited to female providers only. Selection criteria further limited providers by professional qualifications, including only registered general practitioners (GPs) holding an MBBS (Pakistan s medical degree). GPs seemed the best initial Green Star provider class because they offer general medical and pediatric services and can therefore provide a good constellation of care for their clients. In addition, by offering family planning services they could increase their ability to serve their clients and at the same time increase their own income streams and viability. Using GPs as providers also assures confidentiality: clients at Green Star clinics operated by general practitioners might be seeking any number of services other than family planning. For all these reasons, female GPs were the first family planning providers to form the Green Star Network. A smaller number of midwives and lady health visitors who managed NGO clinics were also recruited into the network.

Other criteria used in selecting GS1 providers include:

- having been operational for a minimum of one year with a self-sustaining practice and existing client base;
- being located in an area where low-income people live or work, with a focus on providing services to these clients; and
- being willing to provide family planning services at reduced fees to low-income clients.

Additionally, all GS1 practitioners are required to have access to a medical facility adequate for IUD insertions a private room or screened area for the consultation, electricity, running water, and a clean, well-maintained environment.

Since its inception, the Green Star Network has expanded to include additional cadres of health professionals and male practitioners. Male doctors (GS2) were added to the network to increase the participation of men as family planning clients. Research as well as every-day observation shows that husbands are critical decision makers in family planning in Pakistan (SMAR, 1996; MRL, 1995). Moreover, many Pakistani men will not seek advice from a female doctor. GS2 providers were therefore added to Green Star to motivate men to use contraceptives themselves, talk with their wives about contraception, take responsibility for family planning, and support their wives when their wives choose a method. Further, including GPs who are interested in delivering family planning services but not qualified to perform clinical procedures such as pelvic exams and IUD insertions dramatically expands the availability of basic family planning services and contributes to an extensive referral network.

Pharmacists (GS3) were recruited into the network after GS2 training was well underway. Research indicated that pharmacists were important first sources of family planning information for consumers and could heavily influence their decision to adopt family planning or not. Including pharmacists greatly expands the availability of both accurate family planning information and Green Star products, and facilitates referrals to appropriate Green Star providers.

Junior paramedics were eventually included in the network as GS4 providers because many low-income people who cannot afford doctors go to these health professionals for medical treatment. Many junior paramedics and LHVs work in the poorest neighborhoods, and they often have a larger clientele than many doctors. As with GS2 doctors, GS4 providers deliver family planning counseling services and administration of non-clinical methods such as hormonal contraceptives. GS4 clinics must have electricity and running water, and must be clean and well maintained.

With experience, PSI/SMP has found that ideal Green Star providers generally own their own businesses. These providers tend to be stable in their employment and are also easier to track. They are often younger and more receptive to training, have positive attitudes toward family planning, and are strong entrepreneurial types. Clinics run by husband and wife teams generally do very well, perhaps in part because of the cross-referrals they can provide. GPs just beginning their practices are frequently champions, probably in part because of the benefit they gain from PSI/SMP s marketing services, including local promotional events.

Recruiting providers

At the outset of the pilot project, recruiting physicians to join the Green Star Network was a challenging endeavor. Newly hired field staff had to map out existing providers and identify those with potential to become network members. Mapping strategies included obtaining lists of providers and their addresses from medical associations and pharmaceutical companies, interviewing pharmacists in low-income areas, and simply searching neighborhoods street by street for clinics. Once clinics were mapped out, Green Star staff visited them to identify potential candidates. To be considered, clinics had to meet basic minimum standards, including maintenance of a clean facility, presence of a female GP, and willingness to provide family planning services to clients. Green Star staff would interview those providers meeting minimum standards to assess their level of interest in participating in the network. At this stage in the project selling the concept of the network was as important as screening potential network members.

Enlisting early members was particularly difficult because the Green Star was unheard of. Participating in such a project required a leap of faith on the part of the provider. Thus, the first providers to join the network comprised female GPs who were truly committed to improving their practice and felt that the training they would receive provided enough benefit to offset any risks they might take by being associated with this new initiative. However, training had to be scheduled in such a way that they would not have to close their clinics. This meant revising the training program from five full days to 10 half-days to accommodate provider needs.

The process of recruiting and selecting Green Star Network members has become much easier as the brand has grown in recognition and respect. Membership announcements and applications are made available to providers through PSI/SMP sales promotion officers, journal ads, association meetings, and mass mailings, and interested providers send their applications to Green Star staff. There is now a waiting list to become a member, and Green Star recruiters can apply much more stringent criteria to the provider selection process.

PSI/SMP is currently considering the possibility of charging franchise membership dues. These dues might help to focus the self-selection of franchisees on those providers most motivated to join the network and deliver services in accordance with Green Star protocols. Dues could be used to supplement training and advertising. The feasibility of initiating a franchise dues system depends largely on the benefits providers perceive from being members of the Green Star Network.

Training staff and upgrading facilities

Training is central to assuring the quality of care at Green Star outlets. In order for providers to deliver services according to Green Star protocols, they must be trained in what is meant by quality and how to deliver quality services. To this end, PSI/SMP designed the Green Star training curriculum. Providers must successfully complete this training course before they can be certified as Green Star Network members.

JHPIEGO also provided PSI/SMP its non-country-specific training packages for IUD insertion and removal, infection prevention, and clinical skills. This material provided the framework for the provider training packages PSI/SMP developed. In addition, the PSI/SMP Training Division worked closely with a training consultant to develop the program and a special course in trainer preparation. The curriculum on hormonal methods was based on the results of a training needs assessment among GPs, with existing curricula adapted for presentation through the competency-base training approach.

Special attention was given to staff teamwork in preparing training materials and in training itself. Materials included case studies for analysis and role-playing and discussion exercises, as well as basic family planning information appropriate to each Green Star provider cadre. These materials are presented in the form of a trainer s manual for each of the four categories of Green Star providers and for Green Star trainers. Participants take these materials home for ready reference.

Additionally, PSI/SMP developed a family planning reference manual for all trainees, based on the JHPIEGO *Pocket Guide for Family Planning Service Providers* and reference materials from the Program for International Training in Health (INTRAH). This manual is an easy-to-use guide to delivering family planning services for every Green Star provider. The manual covers client assessment, counseling techniques, appropriate uses for different contraceptives, and side effects management for each type. The manual was designed to integrate well with the Green Star training courses.

PSI/SMP hires medical doctors to conduct in-house training courses, rather than contracting this function out. The arrangement has several advantages. Every doctor—trainer later monitors the clinics of the Green Star providers she has trained, which affords continuity, consistency, and ongoing social and technical support for Green Star health professionals. Additionally, it has been observed that trainees hold their colleagues who serve as trainer—monitors in high regard, a circumstance that may contribute to the motivation of Green Star franchisees. Currently, PSI/SMP maintains 20 Green Star trainer—monitors across the country.

Potential Green Star providers interested in the network who have met the selection criteria are invited to participate in a training course designed specifically for their type of practice. There are four different training courses:

GS1: Licensed female MDs and paramedics. The GS1 course is designed to train and certify female doctors and paramedics with suitable facilities and a successful history of GS4 practice. These registered medical practitioners operate clinics in low-income urban areas. Topics covered include family planning counseling, IUD insertion, prescription and administration of hormonal methods, side effects management, infection prevention, and clinic management. GS1 training is a 40-hour course, given over ten half-days (four in the classroom and six in the clinic). To date, more than 2,000 women have been successfully trained as GS1 practitioners.

GS2: Male and female MDs who do not have IUD delivery capabilities. Male doctors and female doctors who do not have the professional setting or do not wish to provide IUDs receive a one-day course on counseling techniques, hormonal prescription and administration, and management of possible side effects. Of the 4,500 doctors who have successfully trained as GS2s, 70 percent are men.

GS3: Pharmacists. Interested and qualified pharmacists receive a half-day of GS3 training in the importance of family planning, hormonal contraceptives, management of side effects, and recommended referrals. More than 2,500 pharmacists in Pakistan have completed the GS3 training course.

GS4: Junior paramedics. Junior paramedics, including many who work as lady health visitors (LHVs), receive a one-day training course in counseling techniques, hormonal prescription and administration, and handling of possible side effects. More than 2,200 paramedics have successfully completed the GS4 training course.

All four Green Star training curricula address the six essential elements of quality defined in the service delivery protocols. Particular emphasis is placed on developing counseling skills and proactively discussing family planning with clients. In keeping with the CBT approach, every trainee is given the same test, appropriate to his or her provider cadre, both pre- and post-training, to establish a baseline and test the trainee s competency at the end of Green Star training.

To maximize participation and minimize dropouts, courses are held at times that are convenient to providers and a pick-up and drop-off service is offered to each trainee from his or her home to the training location and back. While most training programs in Pakistan offer monetary incentives for participants, Green Star training does not. The lack of financial incentives has not impeded participation.

All health providers who complete the training course and pass the exam are awarded a certificate and invited to become members of the Green Star Network. This certificate has become highly regarded among medical professionals in Pakistan, and the majority of those who receive it opt to join the Green Star. Those who do, enter into a formal franchising agreement with PSI/SMP (see discussion of the agreement below).

Once the agreement is signed, PSI/SMP provides the franchisee with upgrades necessary to conform to specified features of the network (for example, painting or the provision of essential equipment nothing too costly) and installs a Green Star sign outside the outlet, identifying it as a Green Star provider. Outlets are also provided with information, education, and communication

materials, including a counseling flip chart, and family planning product samples. Doctors and paramedics who have been trained to provide IUD services are also given IUD instrument kits and sterilizers.

Green Star certified providers are welcome to participate in refresher training courses at any time and are encouraged to send new staff to training workshops. In some cases, if services are found to be substandard, providers are required to undergo remedial training to maintain their Green Star Network membership.

The Green Star training program is evaluated and refined on a regular basis. JHPIEGO provided a comprehensive evaluation of all four Green Star training programs in 1998 (Vogel et al., 1998). While this study suggested a variety of small improvements many of which Green Star has since implemented the evaluators concluded that PSI/SMP has a strong and effective . . . training program. Notable accomplishments in Green Star training, this study found, include an excellent use of adult learning techniques, trainers who are strong content experts, learning objectives clearly based on identified needs, good use of team training and competency-based training, and strong and effective participation by the learners.

Field support

The extensive follow-up component of the Green Star project sets it apart from most training programs. PSI/SMP has 30 Green Star trainers nationwide. Beyond training, one of their main functions is to perform regular support and monitoring visits to Green Star outlets to answer technical questions, assist with procedures, and identify and solve problems the provider might face in delivering family planning services. Green Star trainers support and monitor the same providers they have trained, providing a sense of continuity and mutual commitment to network members.

In 1999 alone, PSI/SMP training staff conducted more than 14,000 support and monitoring visits to Green Star providers (table 1). Green Star sales promotion officers made an additional 7,631 visits in 1999.

Follow-up visits are made most frequently to providers who are new to the Network, in order to provide them with the support they need to integrate the Green Star family planning component into their practices. As providers become more confident and proficient, the monitoring and support visits decrease in frequency, but they are not discontinued.

The ongoing support function that Green Star trainers perform is vital to ensuring that providers continue to deliver quality services. Green Star trainers visit Green Star providers on a regular basis to assist them with any problems they may be facing in their practice and to reinforce the concepts they learned in training. Trainers can identify if further training is required at a particular Green Star outlet and make arrangements accordingly. Green Star trainers also coordinate the upkeep of Green Star signboards and supply outlets with information, education, and communication materials and Green Star products. Mutually respectful relationships are formed between Green Star trainers and network members. This facilitates the open communication required to identify potential problems and devise solutions, such as remedial training or working groups, before problems become serious.

Additional support is available to Green Star members by way of a 24-hour telephone hotline where messages can be left for Green Star trainers who respond promptly to requests.

Monitoring quality of care

PSI/SMP s quality of care monitoring system seeks to ensure that services delivered at Green Star outlets are consistent with Green Star protocols. When entering into the franchise agreement, providers are informed that the quality of their services will be monitored periodically. The value and success of the franchise depends on the overall quality perception of the Green Star brand, which in turn is dependent on consumer experience and word of mouth. Even a few poor quality sites can damage the brand image and thus the perception of all outlets affiliated with the brand. It is therefore of paramount importance that PSI/SMP monitor the quality of services delivered at Green Star outlets.

PSI/SMP monitors quality of service delivery through two methods: internal supervisory visits and external simulated client surveys.

Internal supervisory visits. Members of the PSI/SMP field staff make quarterly supervisory visits to Green Star providers. During these visits, the staff evaluate selected indicators that reflect the quality of care described in the service delivery protocols, including the outlet s physical condition; record keeping; and information, education, and communication materials; and contraceptive supplies available. For GS1 outlets, the visiting staff monitor IUD insertions and infection prevention procedures. The information is recorded in a supervisory activity sheet and submitted to senior management for review.

Simulated client surveys. PSI/SMP contracts with a research agency to conduct periodic simulated client surveys among Green Star outlets. These surveys involve researchers who pretend to be clients going to Green Star outlets for counseling. Afterward, the researchers record their experience on a monitoring form. The purpose of these visits is to monitor elements of quality of care not easily observed by Green Star supervisors, for example the provider s interpersonal skills, technical competence, choice of methods offered, and so forth. Results of these surveys are submitted to senior management for review.

Management Information System

The Management Information System (MIS) was developed as a tool for program managers to use in monitoring Green Star performance over time. Data on Green Star outlets and from forms completed during support and monitoring visits are entered into the system. Client data and sales figures are also entered into the system. Clinic performance reports are generated to reflect quality of care indicators and quantity of product purchased. The latter serves as a proxy for the number of clients who adopt a contraceptive method at a given clinic.

Referral system

A referral system that links various levels of service providers ensures that clients in need of more specialized interventions, such as IUDs or surgical contraception, are directed to appropriate service delivery points. Two types of referral mechanisms are in place: internal and external. External referral sites include specialized NGOs and hospitals that are equipped to handle procedures such as surgical contraception or complications needing special attention. All Green Star providers also receive an internal referral list that specifies the types of services offered by each Green Star provider. This list facilitates appropriate referrals within the network. For example, a GS2 provider who has a client for whom the IUD is appropriate can easily refer her to a GS1 provider, who is qualified to insert IUDs.

Contraceptive supplies

To ensure that Green Star outlets are able to offer the full range of quality contraceptives at affordable prices to their clients, PSI/SMP markets contraceptives under the Green Star brand and distributes them to Green Star outlets. The Green Star contraceptive portfolio includes the following products:

Touch condoms. Touch is a slightly higher priced condom than PSI/SMP s Sathi brand and public sector products, with a superior quality image.

MultiLoad IUD. MultiLoad is a Cu375 intrauterine device manufactured by Organon.

Nova oral contraceptives. Nova is a low-dose combined hormonal contraceptive pill, manufactured by Schering AG under the trade name Microgynon.

NovaJect injectable contraceptives. NovaJect is a two-month progesterone-only injectable contraceptive, manufactured by Medipharm (Pvt) Ltd., a licensee of Schering AG, under the trade name Noristerat.

Green Star brand contraceptives, with the exception of MultiLoad, are distributed through a commercial distributor to appropriate outlets. (Hormonal contraceptive distribution is restricted to licensed pharmacies.) PSI/SMP also has its own specialty sales force that supplies Green Star products directly to Green Star outlets on a monthly basis. IUDs are distributed only to GS1 providers; the other products are distributed to all Green Star providers. Products are priced so that they are affordable to low-income clients, yet profitable for Green Star providers to sell.

Letter of agreement

As mentioned above, once a provider has successfully completed a training course and decided to become a Green Star member, she or he enters into a formal franchising agreement with PSI/SMP. This agreement functions as an enforceable contract governing the relationship between the two parties. It stipulates the roles and responsibilities of each party and the terms under which the agreement may be terminated. The agreement also protects PSI/SMP s liability.

How the components work together

Together these major components and their operating subcomponents form the foundation of the Green Star Network. The business format defines what the service is and how consumers can expect it to be delivered. The service delivery protocols guide providers. The Green Star brand assures consumers of the quality they will receive from Green Star outlets and creates demand for providers services. Brand equity serves as an incentive for providers to maintain the quality standards needed for Green Star membership. And, most important, the quality assurance mechanisms provider selection, training, support, monitoring, and contractual obligations enable providers to deliver quality services and ensure that they do so in accordance with franchise requirements. The result is increased accessibility and use of quality family planning services in Pakistan.

Green Star management

PSI and SMP created a joint venture partnership, headquartered in the southern region of Karachi, to implement the social marketing project in Pakistan, including the Green Star Network. As the executing agency for the Green Star Network, PSI/SMP has managerial autonomy though it is subject to policy guidance from the Pakistan Ministry of Population Welfare and KfW.

In total, 175 local staff and two expatriate advisors are employed by PSI/SMP in Pakistan.

Organizational structure

PSI designates the SMP executive director, and SMP board members designate the chief executive. The SMP board of directors consists of six SMP members and three members appointed by PSI.

The board of directors has three main roles: providing guidance in strategy and policy; developing contacts with donors and other stakeholders in both the public and private sectors; and providing oversight of SMP management. The board meets every three months and is not involved in the day-to-day management of the organization. At its meetings, the board reviews past activities, discusses the future of the program, and approves each year s financial accounts.

SMP s organizational structure evolved to accommodate its responsibilities as a franchiser. A training division was added and staff hired to oversee and implement the different operational components of the Green Star Network. There are four functional divisions within PSI/SMP: training, marketing and sales, finance, and administration and logistics. A divisional coordinator, who reports to the SMP chief executive and is based out of PSI/SMP s office in Karachi, heads each department. The structure of each of these divisions is further described below.

Training division

The training division comprises three regional field managers who report to the national medical coordinator. Each regional field manager supervises two teams of trainers; each team consists of three to six women and two to three men. Trainers are based in both regional and sub-regional offices; in cities that do not have SMP offices, trainers work from home offices. Each of the three regions also has an administration and logistics officer, a recruitment officer, and an MIS officer. Female trainers work with GS1 and GS4 providers and are associated with particular training sites. Male trainers are mobile and work with GS2 and GS3 providers at various sites. Green Star Trainers are responsible for recruiting Green Star members, organizing and leading training workshops, conducting monitoring and support visits, and coordinating the provision of product and information, education, and communication supplies with sales promotion officers. All trainers have professional backgrounds in health care and have successfully completed the PSI/SMP training of trainers course conducted by PSI/SMP master trainers.

Marketing and sales

Under the marketing coordinator, the marketing and sales department is divided into two distinct functions. One handles the marketing and sales of ethical products and services, including hormonal contraceptives, the IUD, and the Green Star Network itself. The other implements the marketing and sales of over-the-counter products, namely Sathi and Touch brand condoms.

The marketing coordinator ensures that all marketing activities work together to support the overall Green Star campaign. (All products, except Sathi, are linked to the Green Star logo.) The ethical products and services manager is responsible for developing and implementing marketing strategies for the Green Star Network, hormonal contraceptives, and the IUD. This person also supervises three regional sales managers who, in turn, each supervise a team of eight to 12 sales promotion officers. A total of 30 sales promotion officers nationwide are responsible for detailing and selling Green Star products directly to physicians and generating orders from pharmacists in their territories. They also form an important link between Green Star providers and PSI/SMP. A national commercial distributor distributes all Green Star products except MultiLoad to pharmacies through its 10 branches and 150 sub-distributors nationwide. (MultiLoad is distributed to GS1 providers only via PSI/SMP staff.) Area sales managers are responsible for condoms only, and focus primarily on promoting and distributing condoms to non-traditional outlets and monitoring distributor activities.

Commercial and administrative division

The commercial and administration division is in charge of the day-to-day logistics of the organization. This division is responsible for product tenders and procurement, product testing, and warehousing. In addition, the division is responsible for all PSI/SMP-related administrative matters. Hence, the coordinator is in charge of managing all PSI/SMP offices and providing administrative support across the country.

3. IMPLEMENTING THE GREEN STAR NETWORK

The Green Star Network was implemented on a pilot basis from December 1995 to December 1996. The pilot phase involved testing the franchise business model for GS1 in 300 clinics located in two urban areas of Pakistan: Islamabad and Karachi.

Evaluation

The project evaluation was completed in January 1997. The purpose of the evaluation was to assess the effectiveness of the project to date and determine which factors most influence success in order to provide a practical blueprint for expansion. Three types of data were used to evaluate the project:

- results from a series of externally administered surveys;
- information gathered and used in PSI/SMP s internal MIS; and
- qualitative information provided by Green Star field staff.

These three sources of information were combined and compared to formulate and confirm interpretations of perceived trends.

An external research agency conducted two rounds with each of three survey instruments at pilot project clinics to measure changes over time. These surveys were closely modeled on the Population Council s situation analysis approach to evaluating family planning clinic facilities.

Principle findings of the evaluation were as follows (Agha, 1997):

Clinic performance

The evaluation measured the degree to which the project was able to expand the private sector s capacity to provide high quality family planning services and to increase use of family planning and the total number of clients. The evaluation found that:

- There was a doubling of the average number of family planning clients at Green Star clinics within a six-month period (from 1.8 to 4 clients per clinic per day).
- There was a substantial increase in total clients at Green Star clinics during the pilot project period: the average number of clients coming to Green Star Network clinics increased from 14 to 19 per clinic per day.
- There was a steady increase in quarterly purchases of IUDs, injectables, condoms, and OCs by Green Star clinics.
- Prices for IUD and injectable contraceptive administration at Green Star clinics appeared to be higher than recommended.

Quality of care

This evaluation was designed so that the performance of Green Star clinics could be measured in relation to the elements of quality of care as defined in the Bruce–Jain framework both soon after training and again within half a year of training. Overall, availability of contraceptive supplies and counseling skills improved significantly. One remaining weakness among project clinics was the lack of a mechanism to follow up individual family planning clients. Technical competence in terms of clinical skills, specifically IUD insertion and infection prevention, was ensured and evaluated thorough competency-based clinical training before induction into the Green Star Network. Additional findings include:

Choice of contraceptive method

- Availability of IUDs, OCs, and injectables at Green Star clinics increased from 50 percent to over 90 percent during the pilot phase.
- Availability of the agreed upon method during the simulated client survey increased from 76 percent to 96 percent.

Information given to clients

- Providers gave information on three or more contraceptive methods to 86 percent of simulated clients.
- Detailed explanation of how the IUD works, its effectiveness, how it is used, its contraindications, and its side effects increased from over 40 percent to over 70 percent between the first and second round of simulated client surveys.
- Detailed explanation in the case of injection was given by over 60 percent of providers.

Client/provider relations

- In almost all cases, Green Star providers greeted clients respectfully and socialized with them. Other staff members were friendly and helpful to clients.

Follow-up

- By the second round survey, 85 percent of providers informed clients when to return for follow-up.
- Daily record keeping by providers was not complete enough to allow systematic follow-up of new family planning acceptors.

Appropriate constellation of services

- In the design of the Green Star Network, general practitioners were chosen as the most suitable service providers for family planning because they already have the clientele for general medical and pediatric services. Introducing family planning to their range of services allows doctors to serve the needs of their existing clientele better, as well as to attract new clients.

Refinement

Based on the findings of the evaluation, some revisions were made to the franchise business model prior to expansion. These included:

- Selection criteria for GS1 were weighted toward those providers who own and operate their own clinics rather than toward larger clinics or hospitals employing doctors.
- The training was modified to increase emphasis on counseling for side effects.
- Ongoing support was included as a central element in the expansion phase
- The amount of information required for client record keeping and MIS was reduced.

Expansion

After the pilot project, the Green Star Network was expanded in two ways:

- by increasing the number of female doctor s nationwide in the GS1 cadre; and
- by developing alternative service delivery packages to accommodate a wider range of providers in the network.

Since the pilot project, PSI/SMP has expanded the network of GS1 providers from 500 in Karachi and Islamabad to 2,571 nationwide. In 1997, provider cadres GS2, GS3, and GS4 were added, and they have contributed to the growth of the network by more than 9,000 providers between 1997 and 2000. In total, the network now comprises 11,557 providers nationwide (table 1).

Table 1. Growth of the Green Star Network

Year	Female MDs & paramedics	MDs without IUD capacity	Licensed pharmacists	Junior paramedics	Total Green Star providers
1995	300	-	-	-	**300**
1996	499	-	-	-	**499**
1997	1,240	2,724	295	1,038	**5,297**
1998	1,803	3,608	2,529	2,142	**10,082**
1999	2,352	4,258	2,586	2,142	**11,338**
2000	2,571	4,258	2,586	2,142	**11,557**

Numbers of practitioners for each year are cumulative.

4. ACHIEVEMENTS

In just five years of operation, the Green Star Network has greatly increased the accessibility of family planning services to low-income people throughout Pakistan. At the same time, PSI/SMP has grown into one of the largest social marketing programs in the world, as measured both by number of beneficiaries and by level of funding base. This section highlights some of PSI/SMP s major achievements through the Green Star project.

Expanded access to family planning

Through Green Star, PSI/SMP has rapidly expanded physical access to family planning by integrating family planning services into more than 11,000 private sector outlets that did not systematically provide these services.

Not only has the number of outlets providing family planning increased, the cadres of providers who offer family planning services have also been expanded to include private sector pharmacists and paramedics, as well as female and male physicians. Preliminary results of the provider survey conducted by the University of North Carolina (2001) show that members of the Green Star Network are nearly twice as likely to deliver family planning services as their non-Green Star counterparts in the private sector.

Green Star has made family planning services much more geographically accessible to the target population of low-income urban Pakistanis. Green Star health providers provide family planning services to people in 40 urban areas of the country. Fifty million people are within the network s area of coverage.

An estimated 74 percent of Green Star clients are from low-income groups those earning less than Rs 6,000 per month (SMP, 1998).

Green Star has expanded cognitive access to family planning services by increasing awareness of modern contraceptive methods and where they can be obtained.

Knowledge of contraceptive methods is one important determinant of contraceptive use. The Green Star project, through its communications and media campaigns, and highly visible network of service delivery points, has contributed to the substantial rise in knowledge of different family planning methods among women in Pakistan. In 1995, knowledge of any method of family planning was 90.7 percent among married women of reproductive age (PCPS, 1995); by 1997, two years after Green Star began, knowledge among these women had increased to 94.3 percent (PFFPS, 1997). Particularly compelling is increased knowledge about the modern female-controlled methods that Green Star promotes: OCs, injectables, and IUDs. Awareness of OCs increased from 72.7 percent to 86.6 percent among these women; of injectables, from 80.5 percent to 86.0 percent; and of IUDs, from 80.5 percent to 86.0 percent over the same two-year period.

Before women can use contraceptives, they must know where to obtain them. Green Star s advertising and promotions campaigns have been designed to create awareness not only of the methods available, but also of where they can be found. This knowledge, too, has risen sharply since the early 1990s. In the early 1990s, only 25 to 30 percent of married women of reproductive age in Pakistan who knew about the pill, IUD, or injectable, also knew where to get these methods (PDHS 90—91); by 1997, around 70 percent of them knew where they could get contraceptives (PFFPS, 1997).

While some doctor s offices and clinics may have provided family planning services before joining the Green Star Network, these venues were not clearly identified as doing so. Consumers may not have been aware of the availability of contraceptive services. By visibly branding sites with the Green Star logo and advertising the logo as a symbol of **high** quality family planning at affordable prices, PSI/SMP has been able to create widespread consumer awareness of contraceptive products and services and where they can be obtained. A 1997 media effectiveness study found unprompted awareness of Green Star to be almost universal: 94 percent of those surveyed recognized Green Star (AAL, 1997). The Green Star program is successful enough that its name and logo are now synonymous with family planning.

Green Star has expanded psychosocial access to family planning services by integrating those services with a broad range of primary health care and by improving service providers attitudes toward family planning service delivery.

In Pakistan, as in many other countries, there is a heavy social stigma associated with family planning. While PSI/SMP s goal was to increase visibility of family planning services, making them easier to find, it was also important to do so in ways that did not stigmatize those using contraception. To this end, PSI/SMP designed the Green Star program so that family planning services would be integrated with already existing health facilities that are known to offer a range of curative and preventive treatments other than family planning. A client walking into an outlet displaying the Green Star logo is not identified as a seeker of family planning services, and his or her privacy is maintained.

Further, clients may be more inclined to ask Green Star providers for family planning advice because they do not fear being judged by the provider. Training and communications aimed at Green Star providers have dramatically improved their attitudes toward family planning and addressed misconceptions that might otherwise have negatively affected their advice to clients. Providers are also trained to initiate discussion about family planning with clients who may be seeking other services from them.

Improved quality of family planning services

Monitoring and evaluation of the Green Star Network has demonstrated that overall, Green Star providers performance across the six Bruce—Jain quality of care elements is good, and that improvements in quality have continued over time.

A wide variety of studies have shown that Green Star has improved quality of care through the increased skill and competency levels of its providers. An evaluation of the network following its first year (Agha et al., 1997) used several measures, including external surveys, information gathered for the Green Star MIS, and qualitative information provided by Green Star staff. Together these data showed a number of positive findings:

- The availability of IUDs and hormonal contraceptives increased by 80 percent in Green Star clinics.
- The availability of the client s choice of method increased from 76 percent to 96 percent.
- By the end of Green Star s first year of operation, providers gave information about three or more contraceptive methods to 86 percent of simulated family planning clients.
- Detailed explanations were given about the IUD to 70 percent of family planning clients and about injectables to 60 percent.
- In almost all cases, Green Star providers and their staffs treated clients respectfully and cordially.
- By the final survey, 85 percent of providers informed clients about when they should follow up on their visit.

Later research has yielded similar positive results for other groups of Green Star providers. A 1998 study of GS2 providers, based on hundreds of simulated client interviews and direct interviews, and full-day client counts, indicated that these doctors showed improved social skills, improved knowledge of contraception, and greater willingness to promote family planning (MI, 1998). A 1999 study of Green Star pharmacists, based on approximately 1,000 interviews, largely by simulated clients, found that GS3 providers were more knowledgeable about contraceptives, more alert to family planning customers and their needs, and more confident in providing information than untrained providers (Raasta, 1999). Similar research by the same authors on GS4 providers indicated that trained providers rated more highly than comparable untrained providers in terms of contraceptive knowledge, ability to manage side effects, propensity to recommend family planning methods, and willingness and confidence in counseling couples as well as women alone (Raasta, 1999).

PSI/SMP has expanded choice of contraceptives available to low income people through the introduction of four low-cost family planning products under the Green Star brand an OC, an injectable, a condom, and an IUD. These products were developed to fill a market gap between public and commercial sector commodities and are priced at a level that consumers are willing and able to pay. Attractive margins were built into the pricing structure to motivate businesses to stock the products. Green Star social marketed products are distributed through non-network commercial channels, as well as through Green Star outlets. Altogether, Green Star contraceptives are distributed to more than 30,000 retail outlets nationwide.

Increased use of family planning services and methods

Independent research has found that Green Star outlets have experienced an increase in the number of family clients they see (Agha et. al., 1997). During the network s first year, the number of family planning clients seen by female MDs and paramedics more than doubled, from 1.8 to 4 per day, while the total number of clients coming to these clinics increased from 14 to 19 per day.

In order to estimate changes in the number of family planning visits throughout the network, PSI undertook an analysis that projected use based on extrapolations from a limited number of outlets (Hovig, 1999). This extrapolation suggested that more than 10 million visits are made to clinics having female providers annually at least 2 million of them for family planning. From this it is estimated that this type of clinic receives approximately 15 family planning client visits per week (2 million FP client visits per year/52 weeks per year/2,500 GS1 clinics = 15 FP visits per week). Preliminary findings from the UNC provider survey support this estimate. The survey found that Green Star providers of all types received an average of 16 clients per week (UNC, 2001).

Continuing to extrapolate these findings to the entire network of 11,557 Green Star providers, PSI estimates that, overall, the Green Star Network receives some 30 million client visits related to family planning each year. Assuming that each family planning client visits a Green Star outlet at least four times per year (for consultation or re-supply), PSI estimates the total number of clients to be approximately 7.5 million (30 million client visits total/4 visits per client = 7.5 million clients). Some of these clients may be responding directly to Green Star marketing and promotions, and others may have sought out family planning regardless of Green Star. In either case, clients requesting family planning services most likely received better quality care than they would have without Green Star. It is estimated from the retail audit that approximately two-thirds of clients receiving a method from a Green Star outlet receive a Green Star brand. (It is also expected that some portion of clients do not choose to use any modern method despite receiving counseling.)

Table 2. Estimated family planning client visits received by Green Star

Year	Family planning client visits*
1995	7,800
1996	389,220
1997	4,131,660
1998	7,863,960
1999	8,843,640
2000	8,843,640
Cumulative total, 1995—2000	30,250,740

* Estimating that each provider receives 15 family planning clients per week

Since Green Star began, the overall contraceptive market has expanded. In 1998 and 1999, approximately 20 percent of all Pakistani couples who used a modern contraceptive method obtained it through PSI/SMP. In 2000 alone, PSI/SMP products protected nearly one million couples from unintended pregnancies. Since 1995, PSI/SMP family planning products have produced over 4.5 million couple-years of protection. Moreover, these figures fail to reflect notable sales increases in public sector contraceptives during the same time sales that may have been enhanced by Green Star s focused and widespread marketing campaigns.

Sales are a good proxy for measuring contraceptive use. The fact that sales of Green Star and other contraceptive products have consistently increased indicates that overall use of contraceptives is rising. PSI/SMP social marketed products contributed to market expansion both directly and indirectly. The use of hormonal contraceptives (pills and injectables) in particular had been stubbornly low in Pakistan: between 1991 and 1995, contraceptive prevalence estimates indicate that the use of these contraceptives remained virtually flat (see table 11, page 50). Subsequent to PSI/SMP s introduction of Green Star services in 1995 and Green Star s offering hormonal contraceptives in 1996, both sales data and contraceptive prevalence data indicate a significant rise in the use of all modern methods, and particularly of hormonal methods. Between 1996, when Green Star hormonals were introduced, and 2000, the total national market for injectables grew by 53 percent, and for pills by 80 percent (see tables 3 and 4 and figures 5 and 6).

Green Star has had better success with IUDs than with OCs or injectables. Though the tables might seem to suggest otherwise, Green Star has not had much impact on the condom market, nor was it intended to. In 2000, for example, Green Star IUDs accounted for 195,000 couple-years of protection more than Touch condoms, Green Star OCs, and injectables combined. In 2001, Green Star should deliver around 300,000 couple-years of protection with the IUD. This is not surprising considering the historically high discontinuation rates for OCs and injectables in Pakistan.

In the case of OCs, the rising and falling levels of various OC products and programs are due to several factors other than Green Star s influence. Key Social Marketing (KSM) consumers began switching from Nordette 21 to Nordette 28 as Wyeth phased out Nordette 21. Thus, when considering the influence of the KSM OC social marketing effort, it is perhaps more helpful to consider marketing s impact on sales as the net increase between the quantity of Nordette 21 sold before the KSM project (around 500,000 cycles/year) and the quantity of Nordette 21 and Nordette 28 sold during and after the project. For example, in 1999 Nordette 21 and Nordette 28 had combined sales of approximately 823,000 cycles. Thus the net increase that might be attributed to the Key program would be 323,000 (823,000 - 500,000).

The KSM project appears to have been adversely affected by Wyeth s phase out of Nordette 21, the commercial product. However, it does not appear that the Nova OC cannibalized the sales of other oral contraceptives. Nova was a new product provided via a largely new service delivery channel to low-income women. The dramatic drop in sales of Nordette 21 and Ovral is more likely to have been due to Wyeth s exiting from the Pakistan OC market in 2000.

Conversely, Green Star outlets were responsible for much of the increase in statistics for distribution of government contraceptives. PSI did a series of audits at Green Star outlets and found that many were selling government OCs and injectables; the reason is that government contraceptives were cheaper for the service provider to purchase than PSI social marketing brands, and thus they offered the provider a higher margin. These audits indicated that Green Star

product sales did not represent all the CYPs that were being delivered via Green Star outlets. In fact, the total number of CYPs delivered via Green Star was about 50 percent higher than PSI sales statistics show. From all analyses, PSI concludes that Green Star played a significant role in expanding the overall contraceptive market, as well as contraceptive use, particularly for OCs.

Table 3. Total Pakistan oral contraceptive market, 1994—2000

OC sales, in unit cycles						
	SMP s Nova	Nordette 21 (commercial)	Nordette 28 (KSM)	Ovral (commercial)	GoP	Total OC sales
1994	-	405,000	-	560,000	930,735	1,895,735
1995	-	540,000	-	640,000	1,126,655	2,306,655
1996	6,000	516,776	-	644,873	1,327,826	2,495,475
1997	148,000	412,704	103,504	545,433	1,910,917	3,120,558
1998	268,616	235,000	515,446	549,000	1,879,038	3,447,100
1999	346,025	190,000	649,894	542,000	1,945,358	3,673,277
2000	520,000	180,000	684,336	452,000	2,675,238	4,511,574
Cumulative total	1,288,641	2,479,480	1,953,180	3,933,306	11,795,767	21,450,374

Sources: SMP sales from SMP sales report/MIS; public sector sales from MoPW/GoP; commercial sector sales from Wyeth; KSM sales from KSM.

KSM refers to the social marketing effort supported by the Futures Group International.

Table 4. Total Pakistan injectable market, 1994—2000

	Injectable sales, in unit ampoules or vials				
	Commercial sector	Public sector	KSM Depo-Provera	SMP NovaJect	Total injectable sales
1994	67,904	963,234	-	-	1,031,138
1995	74,324	1,268,162	-	-	1,342,486
1996	83,145	1,101,194	-	4,000	1,190,339
1997	65,437	1,522,655	15,943	63,408	1,667,083
1998	29,043	1,497,672	68,073	89,688	1,684,476
1999	33,400	1,407,398	103,614	125,688	1,670,100
2000	25,461	1,454,158	149,302	189,831	1,818,752
Cumulative total	378,714	9,214,473	336,932	472,615	10,404,374

Sources: SMP sales from SMP sales report/MIS; public sector sales from MOPW/GoP; commercial sector sales from IMS; KSM sales from KSM.

To date, PSI/SMP has sold 148,270 IUDs (table 5), generating approximately 518,945 couple-years of protection. *MultiLoad* IUD sales have consistently increased since the brand was launched in 1996, indicating that clients are increasingly satisfied with the method.

Table 5. Total Pakistan IUD market, 1994—2000

	IUD sales, in unit IUDs		
	Public sector	**SMP s MultiLoad**	**Total IUD sales**
1994	420,000	-	420,000
1995	483,000	80	483,080
1996	550,000	5,537	555,537
1997	660,000	18,621	678,621
1998	987,315	27,360	1,014,675
1999	971,056	41,119	1,012,175
2000	756,080	55,553	811,633
Cumulative total	4,827,451	148,270	4,975,721

Sources: Public sector figures for 1994—97 are based on CPR data for IUDs; public sector figures for 1998—2000 are based on MOPW/GoP data; SMP sales are based on SMP sales reports/MIS.

By 2000, sales of the Green Star Touch condom rose to 6 million condoms per year, more than the combined distribution of all other NGOs in the country, and more than any other commercial brand in Pakistan with the exception of PSI/SMP s first condom, Sathi.

Table 6. Pakistan condom market

	Condom sales, in unit condoms				
	Total commercial	**Public sector**	**SMP s Sathi**	**SMP s Touch**	**Total condom sales**
1987	-	-	34,000,000	-	34,000,000
1988	-	-	34,000,000	-	34,000,000
1989	-	-	44,000,000	-	44,000,000
1990	-	-	73,800,000	-	73,800,000
1991	-	-	73,400,000	-	73,400,000
1992	-	-	34,200,000	-	34,200,000
1993	-	-	51,000,000	-	51,000,000
1994	13,700,000	15,700,000	48,400,000	-	778,800,000
1995	17,500,000	15,900,000	58,000,000	-	91,400,000
1996	16,600,000	21,400,000	84,900,000	2,010,002	122,900,000
1997	12,300,000	19,000,000	99,200,000	4,376,496	134,876,490
1998	11,900,000	19,000,000	106,700,000	6,114,033	143,714,030
1999	7,200,000	26,000,000	46,584,000	5,311,605	85,095,650
2000	9,100,000	42,000,000	59,593,488	6,030,394	116,723,882
Cumulative total	88,300,000	159,000,000	847,777,488	23,842,530	1,118,920,018

Sources: Commercial sales are from Aftab Associates Retail Audit; public sector sales are from MOPW/GoP; SMP sales are from SMP sales reports/MIS.

Overall, contraceptives supplied by PSI/SMP represent 20 percent of all modern family planning methods used in Pakistan today and have generated 9,413,041 couple-years of protection since Sathi condoms were first marketed in 1987 (table 7).

Table 7. PSI/SMP CYPs generated since Sathi was launched in 1987

Year	Sathi condoms		MultiLoad IUD		Touch condoms		NovaJect		Nova OC		Total CYPs
	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs	
1987	34,000,000	340,000	0	0	0	0	0	0	0	0	**340,000**
1988	34,000,000	340,000	0	0	0	0	0	0	0	0	**340,000**
1989	44,000,000	440,000	0	0	0	0	0	0	0	0	**440,000**
1990	73,800,000	738,000	0	0	0	0	0	0	0	0	**738,000**
1991	73,400,000	734,000	0	0	0	0	0	0	0	0	**734,000**
1992	34,200,000	342,000	0	0	0	0	0	0	0	0	**342,000**
1993	51,000,000	510,000	0	0	0	0	0	0	0	0	**510,000**
1994	48,400,000	484,000	0	0	0	0	0	0	0	0	**484,000**
1995	58,000,000	580,000	80	280	0	0	0	0	0	0	**580,280**
1996	84,900,000	849,000	5,537	19,380	2,010,002	20,100	4,000	667	6,000	462	**889,608**
1997	99,200,000	992,000	18,621	65,174	4,376,496	43,765	63,408	10,568	148,000	11,385	**1,122,891**
1998	106,700,000	1,067,000	27,360	95,760	6,114,033	61,140	89,688	14,948	268,616	20,663	**1,259,511**
1999	46,584,000	465,840	41,119	143,917	5,311,605	53,116	125,688	20,948	346,025	26,617	**710,438**
2000	59,593,488	595,935	55,553	194,436	6,030,394	60,304	189,831	31,639	520,000	40,000	**922,313**
Cumulative total	**847,777,488**	**8,477,775**	**148,270**	**518,945**	**23,842,530**	**238,425**	**472,615**	**78,769**	**1,288,641**	**99,126**	**9,413,041**

1 CYP = 13 cycles of OCs; 6 injectables; 100 condoms; 0.286 IUDs.

Sales figures used to calculate CYPs are those reported by SMP sales reports/MI.

In 2000, a total of approximately 5,322,001 couple-years of protection were generated by all sectors from modern methods, excluding VSC (table 8). From this figure, it can be estimated that the modern method contraceptive prevalence rate was somewhere around 26 percent (5,322,001/20 million MWRA) in 2000 a substantial increase from the 17 percent reported in1997.

Table 8. Total CYPs from modern methods in Pakistan, 2000

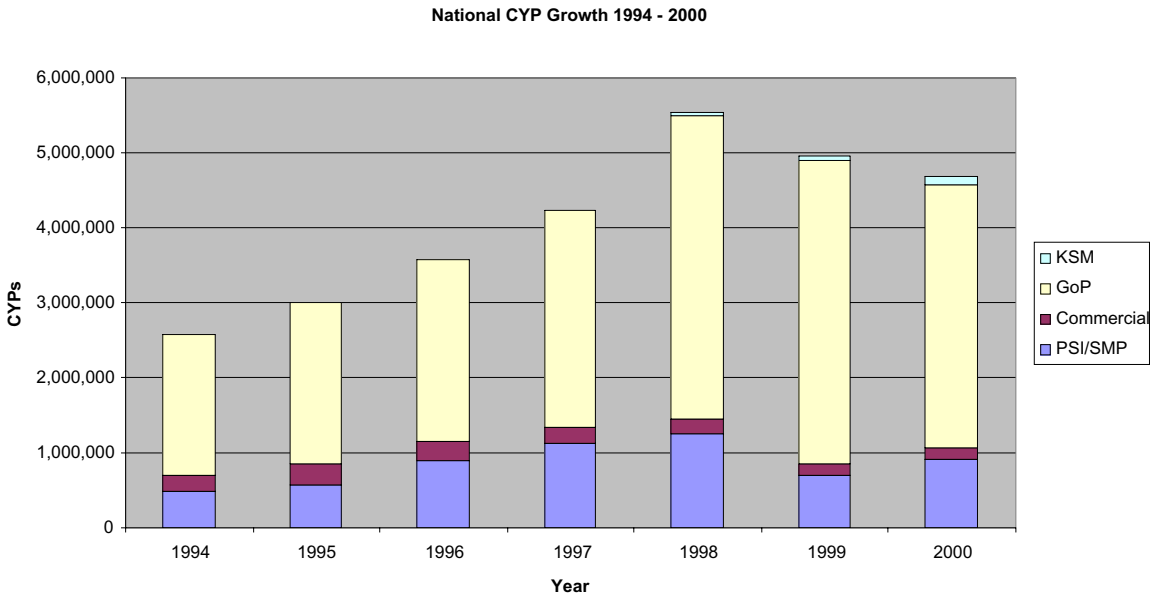
Source	Method				Total
	IUD	Condom	OC	Injectable	
PSI/SMP	194,436	656,239	40,050	31,639	922,363
GoP	2,646,280	420,000	205,788	242,360	3,514,428
Commercial	0	91,000	700,000	4,243	795,243
KSM	0	0	52,641	37,326	89,967
Total	2,840,716	1,166,988	998,479	315,568	5,322,001

Table 9. National CYP growth, 1994—2000

Year	CYPs				
	PSI/SMP	Commercial	GoP	KSM	Total
1994	484,000	222,548	1,859,134	-	2,565,682
1995	580,280	278,157	2,147,526	-	3,005,963
1996	889,787	269,215	2,424,673	-	3,583,675
1997	1,122,920	207,609	2,900,769	11,948	4,243,246
1998	1,259,511	184,148	4,039,756	56,668	5,540,083
1999	710,438	133,874	4,042,905	75,895	4,963,112
2000	922,113	143,859	3,514,427	89,967	4,670,366
Cumulative total	5,969,049	1,439,410	20,929,190	234,478	28,572,127

According to the DHS, contraceptive use increased by 34 percent between 1994 and 1996. The sales data translated into couple-years of protection are consistent with this estimate, showing a 39 percent increase in CYPs generated by modern methods (excluding sterilization) over the same period of time (table 9). Data on contraceptive prevalence beyond 1996 have not yet been gathered. However, sales figures translated into CYPs can be a reasonable proxy for use and suggest that contraceptive prevalence has continued to rise to somewhere around 23 percent in 2000.

Figure 5. Growth in couple-year protection, 1994—2000

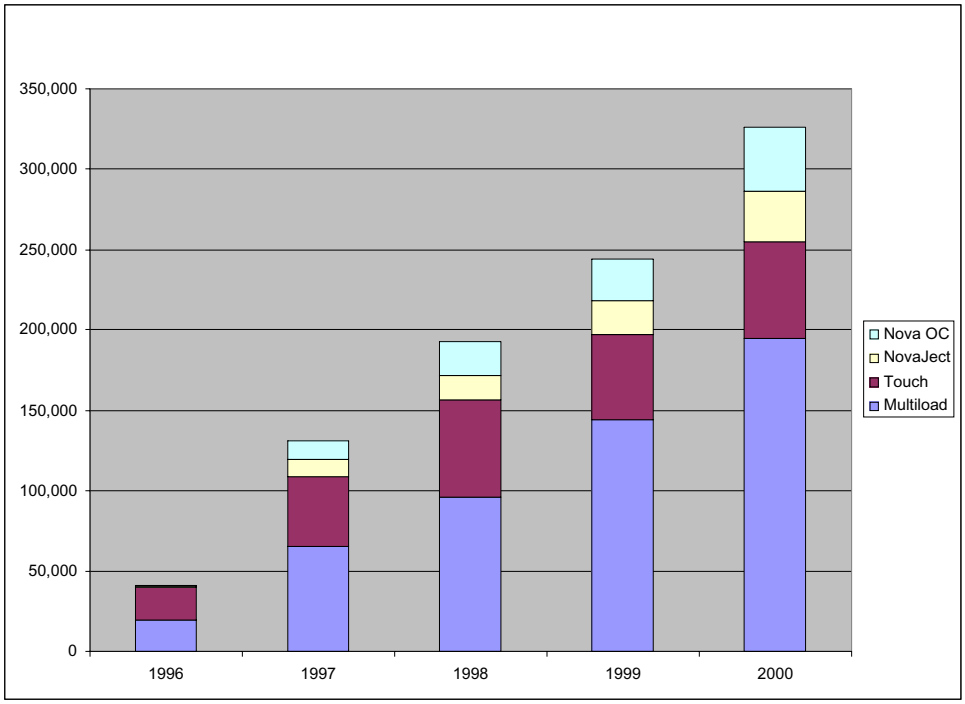


Excluding Sathi condoms from the analysis of couple-years of protection generated by PSI/SMP gives a more direct indication of the role that the Green Star program itself has played in generating CYPs. Such analysis reveals that PSI/SMP, through its Green Star activities, has generated 935,266 CYPs in five years (table 10). Over the same period of time Sathi alone generated 4.5 million CYPs. Green Star products have thus contributed to 17 percent of PSI/SMP s total CYPs generated since 1995. CYPs generated by Green Star products have grown by an average of 36 percent per year over the past few years (Fig. 6).

Table 10. PSI/SMP couple-years of protection generated by Green Star

	MultiLoad IUD		Touch condoms		NovaJect		Nova OC		Total CYPs
	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs	
1995	80	280	0	0	0	0	0	0	280
1996	5,537	19,380	2,010,002	20,100	4,000	667	6,000	462	40,608
1997	18,621	65,174	4,376,496	43,765	63,408	10,568	148,000	11,385	130,891
1998	27,360	95,760	6,114,033	61,140	89,688	14,948	268,616	20,663	192,511
1999	41,119	143,917	5,311,605	53,116	125,688	20,948	346,025	26,617	244,598
2000	55,553	194,436	6,030,394	60,304	189,831	31,639	520,000	40,000	326,378
Cumulative total	148,270	518,945	23,842,530	238,425	472,615	78,769	1,288,641	99,126	935,266

Figure 6. CYPs generated by Green Star products



National contraceptive trends have improved since Green Star began. While these trends cannot necessarily be attributed to the Green Star program alone, they indicate that Green Star has very likely made a notable contribution as part of a combined national effort to improve contraception. Green Star s objective has been to increase both the demand for family planning and the percentage of demand satisfied. Since Green Star began in 1995, overall demand for family planning in Pakistan among married women of reproductive age (women between 15 and 49 years old) increased from 55 percent in 1994—95 to 61 percent in 1996—97 (Table 11). This change represents a growth in demand of 11 percent over two years. Further, the gap between demand and use narrowed, with 33 percent of demand satisfied in 1994—95 increasing to 39 percent in 1996—97 (Fig. 7) a growth in demand satisfied of 18 percent (PDHS, 1990/1991; PCPS, 1994—95; PFFPS, 1996—97).

While contraceptive prevalence rates had been increasing prior to the establishment of Green Star, the rate of increase was lower (see Fig. 7). Moreover, while OC and injectable use rates remained virtually unchanged between 1990 and 1994, use of both methods rose dramatically between 1994—95, when Green Star was launched, and 1996—97 (a 129 % increase for OCs and a 40% increase for injectables). IUD use also increased substantially over the same period, by 62 percent.

High method discontinuation rates in Pakistan in the past have indicated poor user satisfaction and have stifled growth in overall contraceptive use. Green Star s aim is to improve client satisfaction by providing better quality care. This improved care should lead not only to greater client satisfaction, but also to higher continuation rates, and in turn to a higher contraceptive prevalence.

Current use of contraceptives as a proportion of ever-use is one measure of continuation rates, but it is a crude measure: it does not, for example, consider reasons for discontinuation. Ideally, discontinuation rates should reflect only discontinuation due to unnecessary reasons, such as erroneous fears or poor management of side effects among women who still wish to use contraception. A more exact measure can be obtained only by keeping careful records of client contraceptive use over time. While measuring continuation rates by the current- to ever-use ratio is not ideal, it does indicate trends. The data available show that, while continuation rates in Pakistan remain low by international standards, they have improved since 1995. For example, over the two years since Green Star began, OC continuation rates have increased from approximately 12 percent to 21 percent (a 75% increase), and IUD continuation rates have increased from 39 percent to 47 percent (a 20% increase).

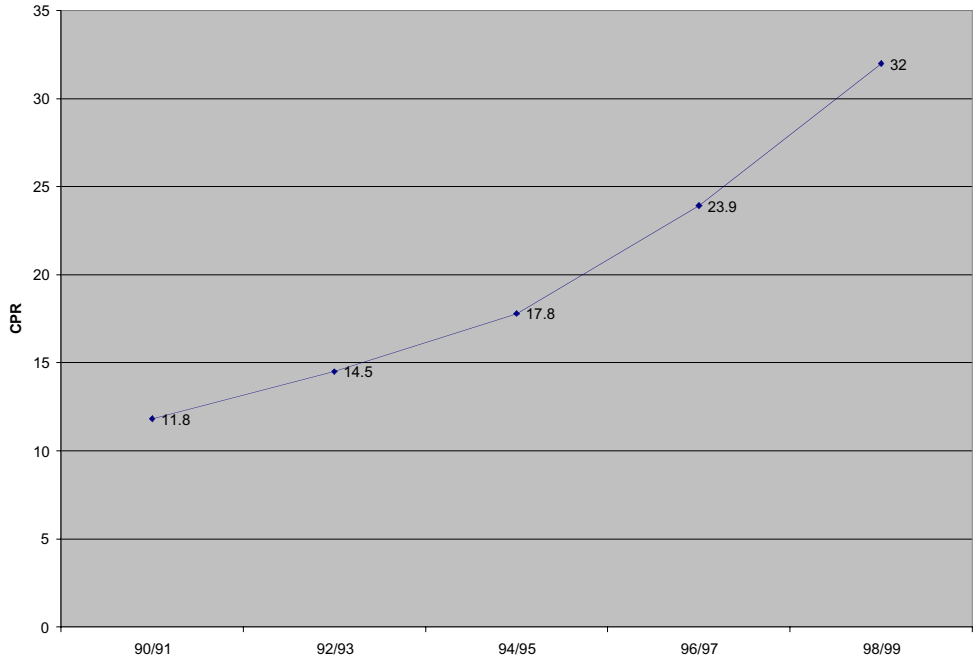
Table 11. Pakistan contraceptive prevalence

Method	Year		
	1991	1995	1997
OCs	0.7	0.7	1.6
Injectables	0.8	1.0	1.4
IUDs	1.3	2.1	3.4
Condoms	2.7	3.7	4.2
Female sterilization	3.5	5.0	6.1
Total modern	9.0	12.6	16.9
Total traditional	2.8	5.2	7.0
Total CPR	11.8	17.8	23.9

Sources: PDHS 1991; PCPS 1995; PFFPS 1997, NIPS

Figure 7. Growth in the contraceptive prevalence rate, 1990—99

Figure 19: CPR Growth 1990 - 1999



Note: 92/93 and 98/99 figures are estimates based on growth trends.

Improved efficiency in operational costs

Figure 8 shows annual cost efficiency trends for PSI/SMP s overall program since its inception in 1987 (year 1 on the X axis in the figure) through 2000 (year 14). Table 12 gives the same information in different form. Overall, the trend in total cost per couple-year of protection is downward, from US$ 8.88/CYP in 1987 to just US$ 4.51/CYP in 2000. Increased costs in 1996 reflect higher expenditures for research, marketing, and training related to the introduction of IUDs, injectables, and OCs.

Fig. 8. Total SMP cost per couple-year of protection, 1987—2000 (years 1— 14)

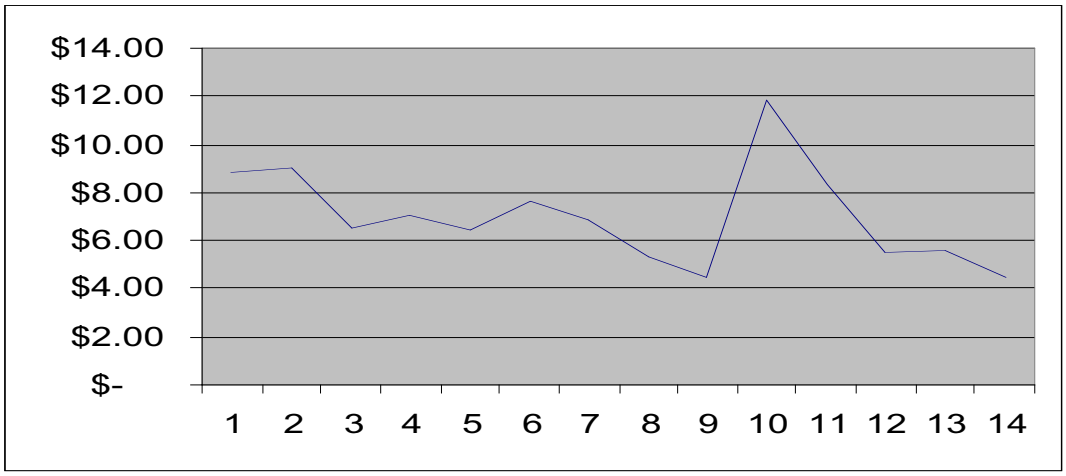


Table 12. Cost per couple-year of protection, 1987—2000

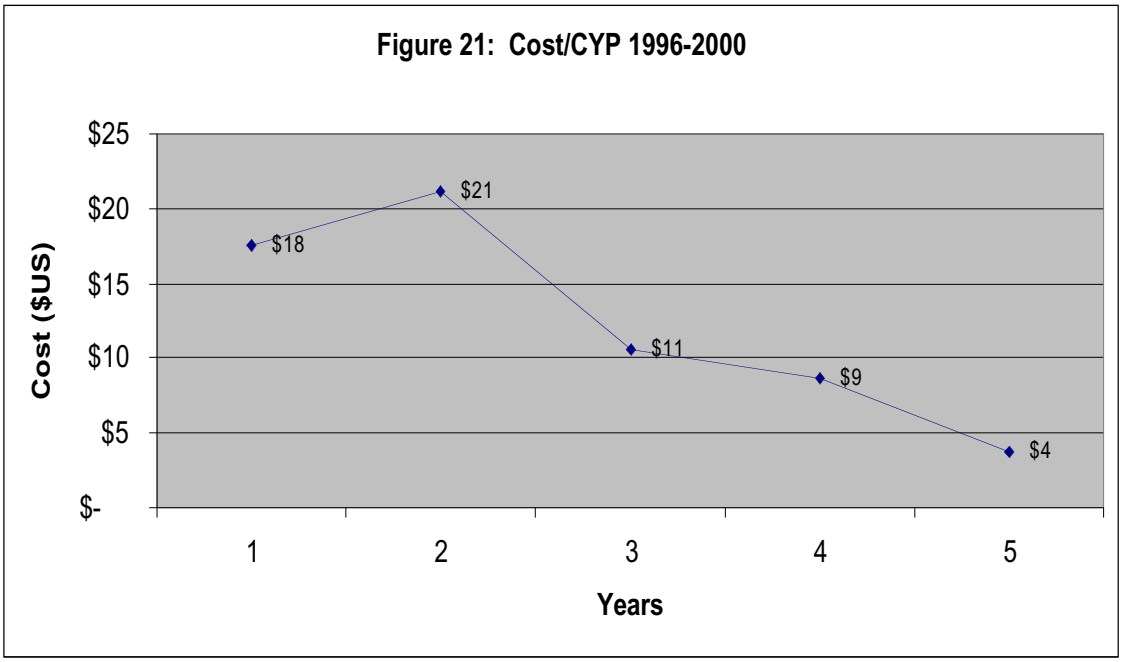
Year	Total CYPs	Total program costs	Cost per CYP
1987	340,000	US$ 3,019,200	US$ 8.88
1988	340,000	US$ 3,056,600	US$ 8.99
1989	440,000	US$ 2,873,200	US$ 6.53
1990	738,000	US$ 5,217,660	US$ 7.07
1991	734,000	US$ 4,704,940	US$ 6.41
1992	342,000	US$ 2,619,720	US$ 7.66
1993	510,000	US$ 3,513,900	US$ 6.89
1994	484,000	US$ 2,560,360	US$ 5.29
1995	580,280	US$ 2,588,048	US$ 4.46
1996	889,608	US$ 10,547,964	US$ 11.86
1997	1,122,891	US$ 9,391,421	US$ 8.36
1998	1,259,511	US$ 6,906,069	US$ 5.48
1999	710,438	US$ 3,954,614	US$ 5.57
2000	922,313	US$ 4,155,341	US$ 4.51

Table 13 and figure 9 show costs and couple-years of protection related to the Green Star project only that is, excluding data for Sathi condoms. In 1996 and 1997, costs are high US$ 18 and US$ 21, respectively, per couple-year of protection due to the significant investments required to launch IUDs, OCs, and injectables in late 1996, and to expand the Green Star network nationally in 1997. Those investments paid off, however, and since 1997 costs have dropped consistently to US$ 4 per CYP in 2000.

Table 13. Cost per CYP since Green Star began, 1995—2000

Year	MultiLoad IUD		Touch Condoms		NovaJect		Nova OC		Total CYPs	Total program costs	Cost/ CYP
	Sales	CYPs	Sales	CYPs	Sales	CYPs	Sales	CYPs			
1995	80	280	0	0	0	0	0	0	280	$ 98,427	$ 352
1996	5,537	19,380	2,010,002	20,100	4,000	667	6,000	462	40,608	$ 714,986	$ 18
1997	18,621	65,174	4,376,496	43,765	63,408	10,568	148,000	11,385	130,891	$ 2,767,843	$ 21
1998	27,360	95,760	6,114,033	61,140	89,688	14,948	268,616	20,663	192,511	$ 2,035,786	$ 11
1999	41,119	143,917	5,311,605	53,116	125,688	20,948	346,025	26,617	244,598	$ 2,096,108	$ 9
2000	55,553	194,436	6,030,394	60,304	189,831	31,639	520,000	40,000	326,378	$ 1,220,564	$ 4

Fig. 9. Cost per CYP since Green Star began, 1995—2000 (years 1— 5)



Beyond taking measures to control program costs, PSI/SMP has also worked to diversify its funding base to maximize financial sustainability of Green Star. PSI/SMP has thus far succeeded in expanding its funding base from Kreditanstalt fur Wiederaufbau only to KfW, the Department for International Development (UK), and the Hewlett and Packard Foundations.

Above all, the network s sustainability is predicated on delivering **high** quality products and services at affordable prices to large numbers of satisfied customers. Green Star has contributed to a marked improvement in the quality of family planning services in Pakistan and has helped increase the demand for and use of these services. As cost recovery increases and operating costs decrease, Green Star will become less dependent on donors for program funds. Because this project serves the poor, however, cost recovery is not a primary objective and may not be achievable for the foreseeable future.

5. PROBLEMS AND CHALLENGES

Existing Green Star operations, combined with PSI/SMP s social marketing of contraceptive products, serve a huge unmet need by delivering easily accessible, inexpensive, **high** quality reproductive health services to low-income Pakistanis. No other nongovernmental reproductive health project in Pakistan has Green Star s geographic breadth, capacity to reach into low-income populations on a large scale, or national impact.

These achievements, however, have not come without problems and challenges centered on establishing and maintaining quality of care, pricing services to give target populations financial access to the network, and maintaining provider engagement with the project. A few of these problems and challenges are outlined below:

Compliance with Green Star quality standards

PSI/SMP s limited ability to enforce compliance with Green Star quality standards has resulted in higher than desired variability in quality among Green Star providers.

Supervisory and simulated client visits to Green Star offices and clinics have found that, while the quality of care at Green Star outlets has clearly improved overall, care remains quite variable among outlets. Over all four Green Star cadres, provider skills both technical and administrative range from excellent to poor, with too many providers falling below Green Star s minimum standards. Some providers focus their practice on particular methods of contraception, rather than counseling women about their full range of options. A PSI/SMP study prompted by the low use of Green Star s MultiLoad IUD by some GS1 clinics found that many GS1 doctors still lack confidence in their skill at inserting IUDs and therefore tend to promote other methods (Rizvi, 1998). Patient follow-up is also too often weak. While most providers tell patients roughly when to return, they often do not take measures to ensure that patients do in fact return. Because client record keeping is minimal, follow up is logistically difficult.

While quality expectations are clearly articulated to providers when they join Green Star and are trained, and franchisees are told that their performance evaluations will be based on these expectations, PSI/SMP currently does little to enforce compliance other than removing the Green Star signboard from problem outlets. PSI/SMP hesitates to remove network members, focusing instead on improving services at poorly performing sites by offering remedial training and encouragement, rather than on penalizing providers. This system should be re-evaluated and strengthened to improve compliance with quality standards.

Mechanisms to control pricing

PSI/SMP s lack of mechanisms to control pricing has resulted in higher than recommended prices being charged for products and services at some Green Star outlets.

Prices charged for Green Star products and services, particularly providing MultiLoad IUDs, are frequently higher than PSI/SMP recommends. Private providers are motivated by profit and will charge accordingly. Green Star does not have adequate measures in place to enforce compliance with pricing recommendations. It may be, however, that pricing takes care of itself by responding to market conditions. While prices are sometimes higher than PSI/SMP would recommend, there is no evidence that pricing at Green Star outlets has posed a barrier to use among the poor.

The need for immediate results

Lack of immediate results that is, increased client flow, the most important franchise benefit has sometimes resulted in decreases in outlets willingness and/or ability to deliver quality family planning services.

Over time, some providers lose their motivation to deliver quality family planning services, and thus their commitment to the Green Star Network. This happens primarily among providers who have not, for whatever reason, experienced a significant growth in business after joining the network. It is difficult to maintain providers motivation without a perceived reward. In several cases, the benefits of delivering quality family planning services are delayed and require patience on the part of the provider.

Maintaining provider skills

A provider s ability to deliver good care may decline over time if he or she does not have the opportunity to practice newly acquired skills with family planning clients.

Green Star providers can obtain remedial training and practice with clients at NGO partner sites, but taking advantage of such opportunities is not always feasible. PSI/SMP needs to develop a more formal mechanism to ensure that Green Star Network members are able to practice the skills they acquire in training. This point also highlights the importance of conducting an ongoing marketing campaign, to generate client flow to franchise members as a way of keeping providers motivated.

Managing a rapidly growing network

Logistical difficulties in managing such a vast and rapidly growing number of outlets have stretched the capacity of PSI/SMP staff to manage the network effectively and have resulted in loss of control over aspects of service provision.

PSI/SMP has to a certain extent compromised quality to promote the rapid growth of the network. Quality can only be maintained through rigorous site supervision and monitoring. A staff of 20 trainers cannot provide adequate coverage for a network of 11,000 providers. To monitor franchisee performance effectively would require that each site receive a supervisory visit at least once a month. A staff of 20, each visiting up to 10 outlets per day (a high estimate), working five days per week in the field, would be able to cover 4,000 outlets total per month (20 staff members x 10 outlet visits/day x 20 days per cycle = 4,000). Clearly, PSI/SMP does not have the resources to provide monthly visits to a network of 11,000, with the resulting loss of control mentioned above.

PSI/SMP has attempted to address these problems through targeted interventions, such as increasing the frequency of monitoring and support visits to problematic outlets; organizing meetings among high and low performing outlets to learn more about the qualities of high performing providers and barriers faced by lower ranking providers; and facilitating the organization of community events designed to generate demand for particular Green Star outlets and enhance provider commitment to the network. In some cases, these interventions have helped motivate providers. In other cases, PSI/SMP decided to end the outlet s membership in Green Star. Further interventions have been designed to address the problems and are described below in section 6, Next Steps.

Sustaining provider involvement

Health care providers involvement and support are crucial to Green Star s success.

The Green Star Network is targeted to low-income women and men with unmet demand for family planning. At the risk of stating the obvious, these customers satisfaction has been essential to the network s success. At the same time, health providers are important Green Star stakeholders. Without their involvement in designing and implementing the project, it is unlikely that Green Star could have earned clients respect and support. Health providers doctors, pharmacists, and paramedics were involved in the development of the service delivery protocols and training curricula through formative research to determine their specific training needs and preferences. PSI/SMP s training team, composed of health professionals, created an ongoing dialogue with the medical community and has thus been able to involve them in the process informally as well.

6. THE FUTURE OF GREEN STAR: NEXT STEPS

With recently awarded funds from the Packard Foundation, PSI/SMP will address several of the challenges described in the previous sections and will build on an already solid foundation to strengthen the Green Star Network and increase its overall impact. Over the next two years, PSI/SMP will work to achieve the following:

- raise the standard of care that is consistently provided by franchisees;
- strengthen franchisee business practices;
- increase client flow to franchisees;
- expand the reach of the Green Star Network;
- broaden the range of reproductive health services provided by Green Star;
- establish integrated Green Star hubs to enhance service delivery and referral at the district level; and
- monitor, evaluate, and disseminate results and lessons learned.

Raising the standard of care

Quality is paramount to the success of the Green Star Network and will be the subject of intensified effort. As noted above, quality has been found to vary among Green Star outlets. PSI/SMP will respond with initiatives including creating refresher training courses for providers; undertaking more rigorous monitoring of franchisees; developing more stringent provider selection criteria based on the experiences of high performing outlets; preparing detailed operations manuals and a more detailed letter of agreement articulating franchise expectations; and instituting quality of care incentive schemes.

Strengthening franchisee business practices

To improve the financial viability of Green Star outlets, PSI/SMP will add a business management module to the training curricula. Also, PSI/SMP will quantify the increased financial returns that result from joining the Green Star Network and disseminate that information to providers to encourage them to improve their business skills.

Increasing client flow

PSI/SMP plans to introduce new outreach strategies that will reach into communities and attract family planning clients. These strategies will include helping Green Star providers focus on catchment areas as marketing units to target for potential clients.

In return for increasing client flow, business volume, and clinician prosperity, PSI/SMP will ask for an increased commitment from Green Star providers to remain members of the franchise. Providers will be expected to contribute to the growth of their clinics, follow certain business practices, deliver quality reproductive health services, and provide timely and accurate data on their work.

Expanding the network s reach

With Packard funds, PSI/SMP will pilot the following two interventions to expand the reach of the Green Star Network to new, underserved, low-income couples in urban slums and peri-urban areas:

- partnering with community-based organizations (CBOs), and
- introducing mobile reproductive health clinics.

At the end of the two-year Packard Foundation grant, PSI/SMP will evaluate the impact of these pilot interventions, assess lessons learned from them, and seek to replicate their successes.

Community-based organizations

PSI/SMP will work initially with 13 CBOs in three urban squatter settlements in Karachi, with a total population of around 120,000. In tandem with the CBOs, PSI/SMP will conduct research to establish a baseline of barriers to contraceptive use and identify productive communications channels and methods. This information will enable PSI/SMP and the CBOs to design appropriate community-based interventions.

Mobile clinics

PSI/SMP will test the feasibility of franchising mobile reproductive health clinics, much as the static clinics in the network have been franchised. These mobile clinics will travel to villages not served by Green Star or other service delivery networks.

Broadening the range of reproductive health services provided

Again, with Packard Foundation funding, PSI/SMP will increase the range of reproductive health services available at selected Green Star outlets. Specifically, PSI/SMP will add three services to the Green Star network: voluntary surgical contraception; treatment of complications after unsafe abortion; and treatment of sexually transmitted diseases (STDs) and reproductive tract infections (RTIs). These services are currently either unavailable or unaffordable among poor women in Pakistan, and those services that are available are of poor quality.

Voluntary surgical contraception. Voluntary surgical contraception (VSC) is currently the most-used modern contraceptive method in Pakistan. Unfortunately, VSC is only recently becoming available through the Green Star network, enabling the network to begin fulfilling one of its reproductive health principles: choice of contraceptive method. VSC has important advantages: it is under the woman s control and does not require partner compliance; failure rates are low; it is permanent; and it requires neither maintenance nor continuous monetary outlay. From a public health perspective, VSC s ease and efficacy translate to substantial demographic impact and reduced maternal mortality.

PSI/SMP will make **high** quality, affordable VSC services available via Green Star. Within the context of the hub system (see p. 59, below), the project will add VSC capabilities to carefully selected Green Star clinics. PSI/SMP will develop a competency-based training curriculum, drawing on materials such as those developed by AVSC International and JHPIEGO. In the context of VSC s permanency, it is especially important that the client s choice is fully informed, and effective counseling will be given the attention it requires. The creation of a competency-based surgical contraception curriculum for Pakistan will itself be an important contribution by the project, as existing curricula are not adequate. PSI/SMP will share the curriculum with other organizations that conduct VSC training, including the MoH.

Post-abortion care. Care for the complications of unsafe abortion is urgently needed in Pakistan. PSI/SMP proposes to integrate post-abortion care (PAC) into the range of reproductive health services offered by Green Star clinics. Once the referral mechanism is strengthened and Green Star Plus facilities (described below) are in place, Green Star will be well prepared to address this difficult problem. The Green Star network provides PSI/SMP with the platform to reach both practitioners and women with information about where to turn during these serious emergencies.

PSI/SMP will select, train and equip its best female doctors (GS1) in medical management and counseling of post-abortion trauma. PSI/SMP will also assess whether changes need to be made in the Green Star referral system to include emergency referrals, for example, by gathering information on emergency transport available, distance to referral doctors offices, etcetera.

RTIs /STDs. The obstacles to diagnosing and treating reproductive tract infections (RTIs) sexually transmitted diseases (STDs) are multiple: time-consuming laboratory tests, expensive prescriptions, unsuccessful outcomes if patients are under-medicated, and lack of protection from reinfection by partners. In addition, people in Pakistan often to seek pharmacist-mediated treatment before turning to a physician.

PSI/SMP will take an important step forward through Green Star by introducing an appropriate technology known as *syndromic management*. Recommended by the World Health Organization, syndromic management effectively diagnoses illnesses through the evaluation of symptoms, without laboratory work. This process has been condensed into simple assessment and decision flowcharts. PSI/SMP plans to complement primary care management of RTIs/STDs by training Green Star providers in syndromic management, and integrating Green Star Plus clinics as referral points for severe, complicated, and drug-resistant infections.

PSI/SMP has experience social marketing an STD treatment kit in Cameroon and Uganda, and will introduce a similar product to Pakistan. The kit s purpose is to enhance the likelihood of a successful outcome, and might comprise STD medication and instructions for use; Sathi condoms and instructions; and educational materials on the need for protection while still infectious, the possibility of reinfection from a partner, the delicate subject of partner notification, and how to avoid STIs in the future.

The kit will be packaged to maximize correct product use, thereby avoiding partial treatment and the consequent problems of recurring infection and resistant bacteria.

Establishing integrated Green Star hubs

PSI/SMP will establish referral and training hubs at the district level, and thereby ensure that clients receive the best available service from the most appropriate provider, strengthening the Green Star franchise as a whole.

At the center of the hubs will be Green Star Plus clinics. Green Star Plus clinics will be developed principally from the most motivated and financially viable GS1 providers (female doctors providing IUDs). Clients will be able to expect the best quality and most comprehensive reproductive health service from Green Star Plus clinics. Green Star Plus clinic staff will be trained to provide VSC as well as other reproductive health services, and will represent the highest point in the Green Star referral network. At the time of this report, six providers have been trained in this procedure, and they form the beginnings of a Green Star Plus provider cadre.

Green Star providers will receive referred clients from community-based organizations (see above) and will in turn be responsible for treating clients or referring them to other Green Star providers in their hub. In this way, clients will enter the Green Star Network in their district at any level and will be referred within an integrated hub to the appropriate counselor and provider, or if necessary, to emergency or specialist services.

The Green Star hub binds all providers in a district into a referral network that:

- provides greater reproductive health impact in the community and broader choice of reproductive health services to the client;
- establishes strong links with the community, as follow-up will be facilitated and inaccurate rumors about family planning limited;
- ensures that clients are referred to the appropriate level of Green Star provider;
- promotes the Green Star franchise, increasing the client flow and financial return to each provider; and
- allows monitoring of impact at a district level.

Monitoring, evaluating, and disseminating results

The activities described in this section will strengthen the capacity of the Green Star Network to deliver quality reproductive health services to low-income Pakistanis. Several research activities will enable PSI/SMP to monitor various interventions and evaluate their impact. Information and lessons learned will be disseminated within Pakistan and internationally in cooperation with the Packard Foundation. Planned research includes the following:

KAP study

A KAP study will be conducted at the beginning and end of the CBO intervention to identify barriers to acceptance of and satisfaction with contraceptive methods and reproductive health care in the organization s catchment area. PSI/SMP will evaluate improvements in these areas at the end of the project.

Consumer profile surveys

Regular surveys will analyze Green Star clients responses to marketing activities and their satisfaction with Green Star services. This information will help PSI/SMP improve interventions over time. The surveys will also establish whether the Green Star Network is reaching its intended beneficiaries.

Monthly sales reports

The PSI/SMP MIS system traces sales performance in all Green Star outlets. These reports will be modified to include the new activities funded by the Packard Foundation.

Sharing information with stakeholders

PSI/SMP will disseminate research results and lessons learned to all project stakeholders, as well as to other donors and NGOs that may be interested. Monthly activity reports and copies of research reports are currently sent to the GoP and other PSI/SMP partners. Toward the end of the two years, PSI/SMP will organize a formal seminar where all stakeholders may present and discuss the results of the Packard-funded improvements to Green Star and share lessons participants have learned in the process.

7. LESSONS LEARNED FROM THE GREEN STAR EXPERIENCE

Evidence to date indicates that the Green Star Network has made notable contributions to family planning in Pakistan. The network s experience has also yielded valuable lessons about social franchising as a model for expanding access to reproductive health services. These lessons should be applied in other circumstances only with appropriate caution. That point notwithstanding, however, many of the things Green Star learned the hard way may be of value to others. A good number of these lessons have become the impetus for new Green Star initiatives, which were covered briefly in the last section, Next Steps.

Perhaps the most important lesson of the Green Star experience is the capacity for social franchising to support a very rapid scale-up in the delivery of health care services. The opposite side of this coin is the great difficulty encountered in monitoring and managing information from a large number of franchisees brought on board quickly. These two facts are reflected in many of the more specific observations offered below.

Project design

All aspects of franchise operations should be field tested and optimized before expanding the network. A great investment of time and money must be made to develop a franchise. Program managers need to remember that franchising is, by definiton, a mechanism for rapidly expanding a proven business model. The entire franchise is at risk of failing if its business model is flawed. The only way to prove the viability of the model is to test it. Before franchising a service, the service delivery model and all its functional components must be developed and tested to ensure that they can be operated feasibly and that, taken together, they bring about the desired result. Only then should expansion of the franchise occur.

The buy-in and endorsement of key stakeholders lends credibility to the franchise and facilitates its growth. Involving stakeholders in the initial design phase of a project is key to obtaining their buy-in. Project managers should ensure that they identify and consult with stakeholders from the outset and that they involve stakeholders in key design issues. It is also important to obtain the endorsement of a locally recognized and well respected medical institution. Potential clients and providers will see the franchise as a much more credible and attractive proposition if it is affiliated with a credible institution such as the local medical association. The likelihood of obtaining such endorsement is greatly increased if the institution is involved in the project design. For example, project managers might submit service delivery protocols to the local medical association for review and approval.

Before designing the functional components of the franchise, the service being franchised must be clearly defined. What is the product? How will it be delivered? To whom and by whom? And under what circumstances will it be delivered? There was a tendency to design functional aspects of the Green Star franchise before defining precisely what they were meant to accomplish. For example, the Green Star training program was designed to impart the knowledge and skills required to deliver services according to the Bruce—Jain quality of care framework. In practice, this meant that while the training curricula defined quality of care, they did not define all aspects of service delivery that Green Star providers would be expected to follow, such as hours of operation, clinic apperance, etcetera. PSI/SMP has sinced recognized the need for clear guidelines covering all aspects of service delivery. These guidelines help both the franchisee and the franchiser understand precisely what it is that they are marketing to consumers that is, what

consumers should be able to expect from franchisees. Only after defining the product should components of the franchise, such as training and evaluation, be developed.

A fully functional and reliable Management Information System must be in place before implementing the franchise so that data can be recorded accurately from the beginning of the project and proper monitoring and evaluation can occur. The MIS should be designed to adapt to changing data requirements over time. Reasonably reliable data are essential to evaluate a program and its effects. While the need for a sound data system seems obvious, experience has shown that it can be very difficult to achieve. The system must be based on a thorough needs assessment and on the development and use of well-designed paper records and data models at appropriate decision points in the program s life.

Additionally, program staff must have confidence in the MIS. If they do not, they will create their own independent systems for record keeping. Reliability problems with PSI/SMP s MIS have resulted in Green Star training, sales, and finance staff maintaining different, overlapping data systems, in addition to the MIS. Not only is this inefficient, but it also results in conflicting information that is difficult for program managers to interpret and manage.

The importance of reliable and coherent MIS data cannot be overstated: information is the basis of the feedback loop that allows the franchiser to monitor franchisee performance and thus maintain appropriate control of the franchise. Data also provide the basis for evaluation, which is critical to assessing and improving the services franchisees provide.

Finally, the MIS must perform a variety of different functions efficiently, such as tracking sales and quality of care, and still yield systematically consistent results.

Over the course of Green Star s development, project staff and management have found it necessary to add new parameters to the MIS, particularly to improve measures of quality, keep track of changes in providers status (progressing from a GS4 to GS1 rating, for example, or leaving one clinic for another), and note the retraining of providers. These new kinds of information and analysis have been added to the MIS on a piecemeal, ad hoc basis.

Finally, the MIS was originally designed to monitor the PSI/ SMP program as a whole. Problems arose when staff attempted to use the MIS simultaneously as a tool to monitor individual providers. Because the underlying MIS data model was not up to this task, the MIS began to produce data mismatches when different types of data analysis were performed. Other problems arose, as well, including inaccuracies in sales tracking, poor or erroneous information supplied by providers, and inadequate efforts to match needed MIS functions with appropriate skills and training in MIS department staff.

A franchise dues system asking franchisees to contribute even a minimal amount should be established from the outset of the project. Asking franchisees to contribute to the network through fees or dues adds value to the franchise, helps screen out providers who are not serious, makes franchisees feel vested in the network and therefore more committed to its goals, and helps with cost recovery. From the outset of Green Star, PSI/SMP was concerned with finding providers willing to participate in the project and was reluctant to create unnecessary barriers to participation, such as charging franchisers a fee. Even so, after establishing a certain degree of brand equity and demonstrating the success of the business model on a small scale, PSI/SMP might have been able to charge membership fees to new franchisees. However, expansion proceeded without introducing a fee system. Recently, when PSI/SMP explored the possibility of introducing fees to assist with cost recovery, it discovered that the 11,000 Green Star members,

some of whom have taken part in the program for five years now, are reluctant to pay for something they already receive for free.

Brand development should accommodate possible expansion of the franchise into new health product categories, such as nutritional supplements for maternal and child health. The Green Star has been promoted as a symbol of Trustworthy Family Planning. As a result of this exclusive association with family planning, the brand will not accommodate the program s expansion into offering nutritional supplements, or working in HIV/AIDS prevention. The equity of the Green Star brand would have greatly facilitated the introduction of these new products and services had it been associated with the broader category of trustworthy health care. Instead, PSI/SMP is developing another brand for which equity will have to be built in the marketplace, a much more difficult undertaking than adding products to an umbrella brand like Green Star.

The international partnership between PSI and SMP seems to be a successful structure for both designing and implementing the Green Star program. The PSI/SMP partnership was based in part on PSI s experiences in other countries. SMP and PSI operate as a joint venture. PSI has a minority share on the SMP board, and an important, though not decisive, voice in SMP strategic matters. SMP is an independent nonprofit organization, as well as PSI s local affiliate in Pakistan. Within the partnership, PSI is specifically responsible for providing technical assistance, fundraising support, new ideas and technologies, and lessons learned from its social marketing programs around the world. PSI also has a fiduciary responsibility vis-<-vis certain donor funds that flow directly to SMP (that is, PSI conducts internal audits and signs off on financial reports to KfW). Over time, PSI has provided technical assistance on MIS, financial management, training curricula design, etcetera. SMP has identified excellent local human resources, implemented the program, and built its own capacity to the point that it now provides technical consultants and assistance to other PSI programs that wish to replicate Green Star.

Implementation

Female service providers have been more effective than males. Research shows that two categories of providers female doctors and junior paramedics or LHVs (lady health visitors) (GS1s and GS4s, respectively) generate the greatest increase in family planning clients. Research also indicates that these providers have been most able to change their behavior and service provision practices to conform to Green Star protocols. SMP contraceptive sales (quantity sold/outlet) were highest to these providers. LHVs particularly work in lower-income neighborhoods, reaching SMP s primary target audience.

The poorest performers are male doctors GS2 providers. They are least interested in providing not very lucrative family planning services, and have not improved their service delivery practices in a substantial way. With the benefit of hindsight, the PSI/SMP should have begun training and franchising junior paramedics and LHVs much sooner, and not spent as many resources training male doctors.

A contractual agreement that clearly stipulates the roles and responsibilities of franchiser and franchisee and a mechanism to enforce contractual compliance (tools to measure performance, a grading system, and standardized action plans for performance levels) are necessary but not sufficient conditions for maintaining control over the quality of services offered by franchisees. A strong contractual agreement can and must be balanced with the need to make membership attractive. With the benefit of hindsight, PSI/SMP believes that establishing a more restrictive agreement with Green Star providers might have encouraged them to better follow recommended practices, procedures, and pricing. Green Star s concern at the

outset of the program was to attract franchisees. For that reason, PSI/SMP sought to offer the most attractive arrangement possible for franchisees. New contracts to be signed with clinics that take part in the Green Star hub system will test the value of stronger contract obligations and enforcement mechanisms.

In implementing the franchise, the focus should first be on quality of providers recruited; second, on quantity. Having a strong sense of the attributes associated with high performing providers (those who achieve impact) will help to inform selection criteria and improve the overall performance of franchisees. The types of providers PSI/SMP recruited for Green Star evolved over the course of the network s development, based on greater understanding of predictors of provider performance. The pilot phase of the project enabled PSI/SMP to identify traits predictive of successful GS1 providers. For example, the better performing physicians are those who own their own clinics, as they are generally more stable and easier to track over time. Also, younger, less experienced providers were found to be more amenable to new service delivery approaches and more motivated to perform well. These and other factors were incorporated into the selection criteria for GS1 providers during the expansion phase. The expansion phase for GS1 providers proceeded cautiously, and each provider was carefully considered before selection. The expansion phase for the other Green Star cadres was much more aggressively focused on increasing the number of outlets. Quality might have been better controlled through more careful provider selection and monitoring.

As noted above, after a national expansion that included paramedics in the network, PSI/SMP found that it might have been better to recruit paramedics among earlier groups of Green Star providers, rather than seeking GPs, particularly male GPs. Not only have paramedics reached more effectively into Green Star s target client group, paramedics also stand to benefit more from association with Green Star than do other providers. Paramedics appear to value the benefits they receive through association with the network and are therefore more highly motivated as a group to maintain Green Star membership by providing quality care.

A strong support and monitoring team large enough to cover franchisees adequately and with appropriate frequency is necessary to control the quality of the franchise. This point has been made at some length in earlier sections, but it is useful to emphasize again the logistical and managerial challenges of supporting more than 11,000 different outlets with supervision and training visits, technical support, and commodity supply. Even so, Green Star s follow-up system limited though it is has proven to be one of the most beneficial features of the network. Having trainers follow up with providers is clearly an important contributor to the program s success. The training course itself is only the beginning of a very long process. Providers need to feel comfortable with their work and stay motivated over the long run. This is exactly what the follow-up system accomplishes. During site visits, trainer—monitors give providers the opportunity to raise questions and concerns. Because trainers personally recruit and teach the providers they later monitor, providers are comfortable with them. Trainers help providers maintain their motivation, even when their family planning clientele is not large. Finally, a strong monitoring and support team is required to ensure that practitioners follow acceptable clinical practices and maintain appropriate client records.

Data collection requirements from providers should be kept to a minimum, and forms designed so that they are easy to complete. Providers are reluctant to keep client records, and any hope of their doing so will be lost if record keeping requirements are too complex or time consuming. PSI/SMP has found that most providers are not accustomed to keeping client records at all and were reluctant to do so for Green Star. The initial data collection requirements were

designed to enable PSI/SMP to monitor a wide range of project indicators, including method continuation rates and client profiles. As it turned out, most providers felt that the required forms were too complicated and time consuming, and many did not complete them. Revisions to client record keeping requirements were subsequently made to reduce the amount of information collected. The result was that more providers were willing to keep records, and the project was able to collect more reliable and consistent, albeit superficial, information about Green Star clients.

A quality training program is extremely important. To the extent possible, the training program should be developed in-house, so that the franchiser has direct control over the quality and scheduling of training. A study tour of Indonesia s private sector family planning project impressed upon the Green Star Network design team the importance of having trainers skilled in both content and training methodology and techniques. After assessing the availability of trainers in Pakistan, it was decided that PSI/SMP would develop an in-house training team and training facilities. The added expense was determined to be minimal in the long run and well worth the benefits of having greater control over the quality and scheduling of training.

PSI/SMP relied on the expertise of JHPIEGO in establishing Green Star training programs for all four cadres of providers. The process involved identifying training needs; developing training curricula to address identified needs; writing a trainer preparation course; recruiting and training master trainers who would be responsible for developing new trainers; preparing training materials and procuring training equipment (for example, Zoe models); and identifying partner NGOs to be used as clinical training sites. JHPIEGO performed a formal and comprehensive evaluation of these training programs and found them to be of very high quality (Vogel, 1998).

PSI/SMP recruited qualified medical professionals (mostly doctors) to perform the functions of training, recruiting, and follow-up for the Green Star Network. This decision was based on the premise that service providers would be more amenable to learning about service delivery procedures from medical professionals than from non-medical professionals, more inclined to value the program offerings, and more willing to participate in the training program. A great deal of the network s success can be attributed to its highly credible and professional training and monitoring staff and the resulting status Green Star has achieved among the professional community of health providers.

Other aspects of the Green Star training program that have contributed to its success include the following:

- scheduling the course so that it is broken into shorter sections over a longer period of time (10 half days for GS1), and accommodating physicians need to maintain their practices while participating in the training course;
- devoting a significant portion of the curriculum to counseling skills; from the client s perspective, this creates a clear point of difference for Green Star providers;
- using audio-visual materials such as videos, slides, flip charts, etcetera, to enliven presentations;
- using JHPIEGO s competency-based training methodology;
- using lifelike pelvic models (Zoe models) and hand-held uteri for skill development; and
- devoting time to developing the trainers.

To the extent possible, community-based activities should be incorporated into strategies to create demand. These activities should involve network members. In the network s first year, marketing was conducted through an intensive initial advertising campaign and through the GS1 female doctors the network had trained. As the network grew, Green Star began to try to reach more potential clients by direct public contact through activities like community meetings, medical camps, and special events. These events attract significant numbers of people from the target audience, and convey more in-depth information than is possible via mass media.

Mohalla meetings (described above), organized by provider clinics with the help of the Green Star field staff, have been especially effective in helping to increase the clientele of the clinics and motivate clinic personnel.

Signboards should be designed so that they are attractive and efficient to produce; systems for installing and maintaining them should be in place before expanding the franchise. A provider s affiliation with the franchise is communicated to the public through the logo displayed at the site of his or her practice. The display should therefore be attractive and visible to passersby. The Green Star logo is displayed at clinics on a signboard. Different types of signboards differentiate different types of providers (GS1 to GS4). GS1 signboards were custom designed for each GS1 clinic, an approach that proved costly and time consuming. Standardized signboards developed for the other types of providers have been much easier to produce and install in a timely and cost effective manner.

Maintaining signboards has proved to be more difficult than expected. Frequent visits to Green Star Network outlets should reveal the condition of the signboard, and any maintenance requirements should be communicated to appropriate personnel for action. Yet gaps have appeared in identification, communication, and follow-up. Franchisers should see to it that a system is in place to ensure that all three aspects of maintenance are fully functional at all times.

Care should be taken to provide ongoing motivation to franchisees. While involvement in the franchise should benefit providers economically, by way of increased clientele, other incentives must be built in to the program to keep providers motivated when they are not seeing clear economic rewards. PSI/SMP has found that giving providers public recognition for their contributions to society through membership award ceremonies with distinguished guests and the press has served to motivate providers. Special events and seminars for Green Star Network members have also proved successful in making providers feel that they are part of something special.

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APPENDIX: GREEN STAR M&E TOOLS

Clinic Grading Checklist

The proposed grading of outlets according to points is as follows:

A = 90 and above

B = 70-89

C = 50-69

D = Less than 50

New changes to be incorporated in the Key of Quality indicators. The key will be updated as soon as inputs about the utility value of the SAS is received.

1. Physical Stamp

1.3.1 **Posters** = 2 new posters currently being developed, we need to mention any GS posters and not just specific posters. ABC are not going to be in use now.

1.3.2 **Brochures** = FP + newer topics brochures under development.

1.7 **Record Keeping** has been given 10 points however if the provider is maintaining a good ML record, she gets 10 points. If she is maintaining some ML and hormonal records, she gets 5 points. If no ML record is being maintained then she gets 0 points.

1.8 **Certificate**: This will not be graded. In addition to GS-1 certificate later on other certificates of e.g., RTI/STDs etc. will be added. The trainer needs to note the availability of the certificate and any comment if required needs to be put down.

2. Procedure Room

2.2.3 Clean sheet has been added to encourage providers to properly cover the client to ensure client s dignity.

2.5.1 Disposable/Surgical Gloves have been added, as they are mandatory in the procedure room.

2.6.1 IUCD Poster: In order to hand the posters, they will be provided in the mounted form by SMP.

3. Infection Prevention

3.2.1 Availability of chlorine solution has been given 6 points if 5% chlorine is being used. However, if any other grand of chlorine is being used then 3 points will be given.

Note:
If Y is ticked then the attained score and the allotted score are the same, if N is ticked then the score becomes zero. There is no intermediary score except in case of 1.7 and 3.2.1 mentioned above.

Supervisory Activity Sheet

GS-1 Trained Outlets

Client Name: _____ Client Code: _____

Provider Name: _____ Provider Code: _____

Month & Year Trained:_____ Staff Code: _____ SPO Code: _____

1st Visit: ____/____/____ Available: o Yes o No 2nd Visit: ____/____/____ Available: o Yes o No

1. Physical Setup

S #				Y	N	Attained Score	Allotted Score	Comments
1.1	Board	1.1.1 1.1.2 1.1.3	Prominently Displayed Attached Properly Good Condition				1 1 1	
1.2	Logo	1.2.1 1.2.2 1.2.3	Prominently Displayed Attached Properly Good Condition				1 1 1	
1.3	IEC Material	1.3.1 1.3.2	Posters Brochures				2 2	
1.4	Counselor Kit	1.4.1 1.4.2	Box with Products Flip Chart				1.5 1.5	
1.5	Privacy for Client	1.5.1	Room/Screen				3	
1.6	Reference Manual	1.6.1	Available				4	
1.7	Record Keeping	1.7.1	Client Card/Record Available				10	
1.8	Certificate	1.8.1 1.8.2	GS-1 Others				0	
Total							30	

2. Procedure Room

S #				Y	N	Attained Score	Allotted Score	Comments
2.1	Board	2.1.1	Room/Screen				7	
2.2	Examination Table	2.2.1 2.2.2 2.2.3	Present Clean Clean Sheet				3 2 2	
2.3	Source of Light	2.3.1 2.3.2	Present Proper				3 3	
2.4	Cleanliness	2.4.1	Trolley				2 2	
2.5	Disposable/Surgical Gloves	2.5.1	Present				3	
2.6	IUCD Insertion Poster	2.6.1	Displayed				3	
Total							30	

3. Infection Prevention

S #				Y	N	Attained Score	Allotted Score	Comments
3.1	Facility for Hand Washing	3.1.1 3.1.2	Washbasin Present Soap Present				3 3	
3.2	Chlorine Solution	3.2.1 3.2.2	Available Bucket/Tub Available				6 4	
3.3	Components of Instrument Cleaning	3.3.1 3.3.2 3.3.3 3.3.4	Detergent Present Brush Present Utility Gloves Present Washbasin Present				2 2 2 2	
3.4	Components of Instrument Boiling	3.4.1	Boiler Present				4	
3.5	Components of Instrument Storage	3.5.1	HLD Container Present				4	
3.6	Antiseptic Solution (except Dettol)	3.6.1	Available				2	
3.7	Destruclip	3.7.1	Available				3	
3.8	Method of Clinic Waste Disposal	3.8.1	Plastic Bag in Bucket/Basket				3	
Total							40	

A=90 and above

B=70-89

C=50-69

D=Less than 50

Final Attained Score: _____

Attained Grade: _____

Action Plan: _____

_____

APPENDIX: GREEN STAR NETWORK S PROVIDER SERVICE-DELIVERY PROTOCOLS

Choice of methods

Green Star providers must:

- Have an adequate supply and range of family planning methods available.
- Ensure that client is counseled on range of methods available.
- Ensure that client receives chosen method.
- Refer client to another SDP for methods that are unavailable at that outlet.
- Not place unnecessary restrictions on client eligibility for a particular method.

Information exchange

Green Star providers must:

- Give an overview of all available methods to first time and undecided clients.
- Give in-depth information about the method requested to client, including side effect.
- Ask client questions to clarify her/his particular family planning needs.
- Make information, education, and communication materials on methods available to clients.
- Give information in a complete, concise, and non-biased manner.
- Refer clients to other sources for further information if needed.

Technical competence

Green Star providers must:

- Be knowledgeable about contraception and be able to explain contraceptive benefits, risks, eligibility criteria, contraindications, side effects, and management of side effects.
- Be able to demonstrate skills in hormonal method administration (GS1, 2, and 4 only).
- Be able to demonstrate skills in IUD insertions (GS1 only).
- Prescribe methods appropriately.
- Ensure that all new staff who will be delivering family planning services to clients receive Green Star training.
- Follow proper infection prevention procedures.

Interpersonal relations

Green Star providers must:

- Establish friendly, polite, respectful, and nonjudgmental rapport with clients.
- Respect privacy of clients.
- Ensure that all staff at their outlet are polite and friendly to clients.

Continuity of care

Green Star providers must:

- Be able to recognize and manage possible side effects associated with methods.
- Be able to resupply client s contraceptive method of choice easily.
- Encourage client to return as needed.
- Schedule appointment for return visit.
- Maintain records of client visits.
- Refer client to higher-level service provider if necessary.

Acceptability and appropriateness of services

GS3 providers must ensure that:

- The pharmacy is neat.
- Information, education, and communication materials are displayed.
- The Green Star signboard is maintained.
- Green Star products are stocked and stored in a neat, clean, and appropriate manner.

GS1, 2, and 4 providers must ensure that:

- Waiting room is clean and has family planning poster and information, education, and communication materials displayed.
- Exam room is clean and private.
- Clinic has running water, electricity, and toilet.
- Costs of services are acceptable to all clients.
- Days and hours of operation are convenient to clients.
- Client waiting time is reasonable.
- Confidentiality of client is maintained.
- Other health services are available at the clinic.